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ABSTRACT

The development of community-based programs to support inexperienced parents through home visits by experienced mothers, who are in turned facilitated by child health and development professionals, has become an increasingly common approach in Europe and the United States. This edited volume presents proceedings from an invitational conference on innovative community-based support programs for children and their parents, held in Amsterdam in 1996. Focusing on program implementation, research, development and dissemination strategies, specific target groups, and the role of lay persons in service delivery, the chapters are: (1) "Community-Based Innovative Practices in Child Health Care: Early Childhood Care and Development Programs" (Marian Hanrahan); (2) "The Mothers' View on Community Based Programs" (Carolina Kleinjan-Rens); (3) "The Community Mothers Programme in Dublin" (Brenda Molloy); (4) "Effective Strategies of Psychosocial Prevention: A Conceptual Analysis" (Jo Hermanns); (5) "Community-Based Early Childhood Development: Wider Implications of the New Movement" (Walter Barker); (6) "Rural Families, Rural Strength and Hope" (Barbara Clinton, Judy Matthews-Taylor); (7) "Parenting Programs in South Wales" (Maria Gallagher, Joy Mason, Jill Rossiter, and Miskey Sandison); (8) "National Parent Support Program in Ireland" (Chris Sheridan, Joan Roberts, Aidan Warner, Anne Coyle, and Pat O'Rourke); (9) "Mothers Inform Mothers: An Innovative Child Care and Development Program in the Netherlands" (Marian Hanrahan, Bert Prinsen, and Yvonne de Graaf); (10) "Research to Fit Practice: Innovative Action Research in Health Promotion" (Maria Koelen and Marian Hanrahan); (11) "Increasing Coverage of Programs for Children: Approaches, Strategies and Conceptual Issues" (Nico van Oudenhoven and Rekha Wazir); and (12) "Issues of Program Design and Implementation" (Bert Prinsen). Most chapters contain references. (KB)

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COMMUNITY HEALTH, COMMUNITY CARE, COMMUNITY SUPPORT

MARIAN HANRAHAN
BERT PRINSEN (EDITORS)

Proceedings of the invitational conference on innovative childhood care and development support programs

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MIM COOPERATIVE

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COMMUNITY HEALTH, COMMUNITY CARE, COMMUNITY SUPPORT

Proceedings of the invitational conference on innovative childhood care and development support programs

Marian Hanrahan and Bert Prinsen (editors)

Netherlands Institute of Care and Welfare
MIM Co-operative

COLOPHON

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FOREWORD

'Community health, community care, community support' - reflections on community-based support programs for children and their parents - is concerned with the health and welfare of all young children and their parents. Some children and parents are more deprived in this respect than others, especially children with special needs or living in underprivileged conditions. In many countries it has been recognized that special attention is needed for these children and their parents.

The Bernard van Leer Foundation supports activities by means of financial and professional support to help these parents and children to help themselves and to develop abilities to overcome adverse conditions. This calls for empowerment. One way to achieve this is by offering support from the immediate environment. Not necessarily by nurses, doctors or child care workers, but rather by low profile volunteers: often mothers living in similar circumstances. Solidarity and intuition - faith in one's own abilities and qualities - play a major part in this support.

Comparing these support programs leads to surprising conclusions. There are differences, but perhaps even more similarities. The important part of the target group, the mothers themselves, stands out in all countries. It also appears to be an universally fact, that it is very difficult for professional health workers to adopt an empowering attitude. Community based support programs deal with activities which influence (mental) health, parenting and social life. To evaluate and identify measurable outcomes which lead to showing substantial effects on the target populations is particularly complex.

In this perspective we are fortunate that a group of 30 representatives of different programs from nine countries has accepted the invitation of the MIM Co-operative and the Netherlands Institute of Care and Welfare for a conference on innovative community-based support programs for children and their parents, in Amsterdam, september 1996. Internationally operating professional workers in the field of parenting support and health-promotion (socio-medical experts, nurses, pedagogues, social workers) together with a few mothers have examined these programs. Bottlenecks in the development and evaluation research were identified, the opportunities and limitations for large-scale implementation were deciphered.

In this age of high-speed developments it is invaluable, that mothers, health care workers, researchers and policy makers together look into the opportunities and limitations of these programs. It increases the possibilities for innovation and it provides a perspective for broad-scale implementation. The Bernard van Leer Foundation, the Netherlands Institute of Care and Welfare and the Dutch MIM Co-operative contribute each in their own way to enhance internationally these community-based support programs. We do this, fully convinced of the opportunities of these types of programs. We are confident that before

too long evaluative research will underline this conviction with proof of effectiveness. The different outcomes of evaluations in Dublin, Bristol, Tennessee and Breda is already pointing in that direction. At present all we want to do is to introduce the 'community-based support programs for children and their parents' to you. The major similarities between the programs in the various countries are worthy of further dissemination. We hope you find this book as stimulating as we do.

Prof. P.A.H. van Lieshout,
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MESSAGE FROM THE EDITORS

One of the activities of the MIM Co-operative and the Netherlands Institute of Care and Welfare in 1996 was the organization of an international conference for workers and managers in Early Childhood Care and Development (ECCD) Support Programs. These programs are developed and used by mothers with the support of other mothers who in turn are facilitated by nurses, developmental psychologists and others. It is appropriate that the story of one of those mothers, Carolina Kleinjan's presentation at the conference, is used as the first chapter of part I of this book. Carolina was one of the inexperienced mothers who received the program initially. She is now one of the voluntary experienced mothers in Breda, visiting and sharing her experiences with inexperienced parents. The participants at the conference found recognition in the type of comments she made. All said: "Our visiting mothers, in Britain, Ireland, the USA and Wales, say exactly the same things."

In this book you will find the building blocks for discussion, the different experiences of several ECCD-support programs in different European countries and the United States of America, each with their own perspective but based on common principles. We have focused on five topics: implementation, research, policy, specific target groups and the role of lay person delivering part of a very important service in their own communities. In this book we present the different contributions of key note speakers and we have incorporated the discussion topics so that others who were not at the conference may share our experiences. We hope that this book will bring to you 'the state of the art' of the different, but also very common early childhood care programs in several countries. The director of the Community Mothers Program from the Eastern Health Board Dublin, on which a lot of the programs are based, was one of the keynote speakers. Her program is the largest program of its kind and has been evaluated successfully, whilst the Irish Department of Health in 1996 has endorsed the program in their national policy document.

Some of the organisations have implemented the European child care legislation in their own policies and they see this type of programs as an opportunity of delivering services by members of their own community. The ECCD support programs in Ireland, for example, are used to bring child health and welfare services closer to families in need, whilst in the United States of America the programs serve communities who might otherwise not use the services at all.

In 1991 the Commission's Equal Opportunities Unit started as part of the Second and Third Community Action Programs for Equal Opportunities a 'Childcare Network' which since then has been re-named the 'European Commission Network on Child care and Other measures to reconcile Employment and Family Responsibilities of Women and

Men'. In a recent report the Network published a set of principles and objectives for the development of services for young children (Moss 1996)[1]:

- Child care services need to be affordable and within easy access in all (rural and urban) areas.
- They need to focus on all children, but especially on children in need[2].
- The services need to combine reliable (health) care with a pedagogical approach.
- Close and responsive relations need to be in existence between services and parents and local communities.
- The child care services need to be diverse and flexible with an increasing choice for parents. And finally,
- Coherence between services need to be reached with an opportunity for basic and continuous training appropriate to the educative and social value of the work.

Europe has always been diverse - culturally, linguistically, politically and in other ways. Responding to this diversity is a challenge. This challenge could become a problem when services and policies are inflexible and if a uniform approach is wanted. Diversity of perspectives brings a richness to debate, assists self-reflection and provides a dynamic for the evolution of theory and practice.

The ECCD support programs we discussed during the conference adhere to the principles and objectives we just have mentioned. Needs are increasingly diverse and the circumstances are subject to change. Exclusion and inequality are more prevalent, with many local communities losing their cohesion. And the different needs are often inter-related. The interventions in our programs are set in real life and are based on the importance of social aspects of health problems (as opposed to purely individual problems). Concepts such as equity, socio-economic differences between groups and the influence of organisations, environments, culture, habits and governments on health behaviour, are all on the agenda. Different authors in this publication have addressed this topic in depth and from different angles. The programs help and enable parents to gain confidence in themselves whilst at the same time handing them tools to take control of their own lives. One of the spin-off effects of these programs is the step that women make towards paid employment or towards further studies as some community mothers in Britain, Ireland, the USA and the Netherlands have done.

Jo Hermanns is convinced that the future of working with disadvantaged families and children lies not in a medical prevention model, but in a contextual family support model. Walter Barker discusses the wider implications of community-based and community driven early childhood development programs. Cohesion is important. But, unfortunately child care services do not operate within a coherent framework. Often the facilities and services are divided between health, welfare, and educational systems which in turn may lead towards an insufficient use of resources. As a result, one may hear the question of who is responsible for the service? Private individuals such as parents already assume a heavy responsibility for managing the relationship between employment and family life. Social partners and governments have a leading responsibility for the provision of adequate child care facilities and leave arrangements with corresponding measures to support the family during this period.

We hope this book may help towards the development of a dynamic European model of care, targeted at and enhancing services for parents and children in need. Marian Hanrahan introduces the goals of this book and the original goals of the invitational conference in Amsterdam. Thereafter ECCD support programs are described in part I from four different points of view. Carolina Kleinjan presents the mother's view, Brenda Molloy introduces the professional view, Jo Hermanns the theoretical view and Walter Barker the ideological.

A large part of the book is devoted to the actual programs in different countries. In part II you will find a description of programs in Tennessee USA (chapter 6), England and Wales (chapter 7), Ireland (chapter 8) and the Netherlands (chapter 9). They are examples of good practice and perhaps they may give you new ideas.

We were very excited to learn that the common principles on which the programs are based translate well within the different cultures. So, in part III we reflect on the lessons learned of community based supportprograms for children in need and their parents. Maria Koelen and Marian Hanrahan look (chapter 10) at the programs from a researcher's point of view. The invited contributors Nico van Oudenhoven and Rekha Wazir (chapter 11) then reflect on realistic expectations for this type of ECCD programs. Finally, Bert Prinsen makes some closing remarks (chapter 12) on the lessons learned from developing, designing and the implementation of community based support programs. We are convinced that the unique combination of expertise is beneficial to the further plans and development of Early Childhood Care and Development Support Programs.

Bert Prinsen and Marian Hanrahan
Utrecht / Dublin, September 1997

Note 1
Moss, Peter (1996). *The EC Child care Network 1986 – 1996: a Decade of Achievements*. This report has been prepared for use within the Commission. It does not necessarily represent the Commission's official position. Network Coordinator is Peter Moss, Thomas Coram Research Unit, 27/28 Woburn Square, London WC1H AA.

Note2
Children in need are defined as those with disabilities and those whose health or development, in the broadest sense, would be impaired or limited without the provision of such services.

INTRODUCTION

1. COMMUNITY-BASED INNOVATIVE PRACTICES IN CHILD HEALTH CARE: EARLY CHILDHOOD CARE AND DEVELOPMENT PROGRAMS[1]

Marian Hanrahan

Introduction

Growing awareness of the importance of and demand for early childhood programming has created a need for knowledge and processes that can inform planning and program choices in what is a rapidly advancing field. Children in need are defined as those with disabilities and those whose health or development, in the broadest sense, would be impaired or limited without the provision of such services. To meet those needs and to enhance the well-being of young mothers and their babies an international conference was organized with an opportunity to:

- exchange experiences, methods and effective strategies with community based early childhood developmental programs;
- discuss the generalisation and implementation of effective, preventive strategies and methods of health promotional activities for parents with babies aged 0 to 18 months;
- start an international network with the view of strengthening international exchange of program information.

> The conference gave opportunities to help finding the answer to the following questions:
> 1 What are the effects found as a result of ECCD-programming?
> 2 Which conditions need to be met to reach optimal results?
> 3 Which strategies are helpful and effective changing the current statutory services systems in such a way that they enhance the needs of children living in deprived circumstances?

Children in need

One and a half billion children will be born in the decade of the 1990s[2]. The great majority will be born in what are commonly referred to as "developing countries". Increasingly, due to economic conditions, children in these countries will be born into poverty and situations which threaten their chances for optimal human growth and development. However, poor living conditions do occur in developed countries also (Townsend & Davidson 1980). Migrant workers and refugees often live in poor housing conditions and the growing number of people living rough are a new fact of life. World-wide, the quality of the environment in which millions of children are growing up is inadequate by any number of criteria. Overcrowding, lack of potable water and sewage

facilities, lack of adequate food, and inadequate caretaking characterize the environments of many young children.

In most of the countries represented by the participants of the conference we do not have the large scale problems that exist such as starvation, lack of access to health care and the lack of support services for protection of young children. Nor do we have large scale refugee camps close to war zones. But, as illustrated by Myers, in the developed countries there are still determinants present which can prevent healthy children from reaching their full potential. *"Many of the same conditions of poverty and stress that previously put children at risk to die now put them at risk of impaired physical, mental, social and emotional development in their earliest months and years. Delayed or debilitated development in the early years can affect all of later life. It can also be prevented. And, because children are amazingly resilient, it can be overcome. But overcoming early difficulties is not only inefficient, it requires greater commitment than most people in privileged positions have been willing to give, up to now. As a result, millions of children will be deprived of their right to healthy and normal development. They will fail to live up to their potential and will be further thwarted in their attempt to escape from the persistent cycle of poverty. Many of the survivors will lead lethargic, unproductive, unrewarding, and dependent lives"* (Myers 1992;1995).

Frequent infection (most commonly diarrhoea) and malnutrition account for over 50% of infant deaths in developing countries. But, malnutrition and diarrhoea do also occur in developed countries, if only for different reasons. British nutritionists recently warned health conscious parents and vegan parents against the use of low fat yoghurts, other low fat milk products and 'light' drinks. These parents should make sure that their children receive sufficient carbohydrates, fat and proteins, as growing toddlers with low fat, low carbohydrates and low protein intake were showing signs of malnutrition. At the same time the admission of infants and young children in hospitals during summer months is increased, due to overheating of the baby, lack of fluids, contaminated food and drink (diarrhoea and dehydration).

In terms of physical, intellectual, emotional and social well-being, the period from conception to age six is the key to subsequent growth, development and ultimate productivity. From the prenatal period through the sixth year there are distinct stages. The stages include: intra-uterine, intrapartum (birth itself), post partum (birth to 1 month), early infancy (first 6 months), late infancy (6 - 12 months) and toddler stage (1 - 3 years). Some children start life with a disadvantage, as they may have suffered a birth trauma, are born too early or too late or have weight too low according to their gestation. Or they may indeed suffer from a congenital defect. Children have different needs, depending on where they are within these stages. In order to create a program for young children, it is critical to have more specific information on their needs. A delineation of developmental differences is provided for the first two age groups (Donohue-Colletta 1992):

Infant's need

- stage protection from physical danger
- adequate nutrition
- adequate health
- adults with whom to form attachments
- adults who can understand and respond to their signals
- things to look at, touch, hear, smell, and taste
- opportunities to explore the world
- appropriate language stimulation

Toddler's need

- same needs as in the infant stage, plus:
- support in acquiring new a chance to develop some motor, language and thinking skills
- a chance to develop some independence
- opportunities to begin to learn to care for themselves
- help in learning how to control their own behaviour
- daily opportunities to play with a variety of objects

Children living in socially deprived circumstances

Health inequalities have been found in all countries where research on socio-economic health differences (SEHD) has been carried out (Laughlin & Black 1995). Children from deprived backgrounds score poorly on many health indicators. The prenatal and infant mortality in children from low socio-economic groups is several times higher than those from a high socio-economic background. Differences are also noted in birth weight and size. Social inequality is often seen as an important environmental determinant of children's health and well-being (World Health Organization 1993). Studies on accessibility of health care and behaviourial risk factors are frequently the object of interventions. Physical and environmental factors, like maternal deprivation or living conditions, appear to have rarely been the object of interventions. Health educational approaches offer a promising perspective to reduce SEHD but mass communication, like written educational materials, does not seem to work in low socio-economic groups. Showing a video tape, or work face-to-face and step-by-step with others, seem to have the effect of redressing risk factors or adequate use of services (Gepkens & Gunning-Schepers 1994). The ecology of the family (specific situation and location) has a greater influence on development and upbringing than is generally assumed (De Winter et al 1995). In deprived areas in the Netherlands, a Dutch version of the Home Instruction Program for Pre-school Youngsters (HIPPY) is widely available to deal with pre-schoolers as young as 1.5 years of age up to age 4.

In our programs we often aim to target the disadvantaged sections of our communities. Usually they are socio-economically disadvantaged. Examples are the mother who uses hard drugs, teenage and travelling mothers, migrants (including refugees). These travelling mothers could be divided in the traditional Romany, Cinti, new age, or like in Ireland, the indigenous travellers. The use of our type of programs is one of the possibilities of contributing change and could work positively on women's health.

Position of mothers using hard drugs

There are very few ECCD programs geared towards mothers using hard drugs. If mothers are using the statutory services they have difficulty adhering to the appointed times. Therefore, specialized and usually small surgeries exist to deal with the specialized care that these mothers and babies need. They are often organized by voluntary agencies or

sometimes by a municipal health authority. In some countries mothers who 'do drugs' are in danger of losing their child, due to the professionals' fear that the situation is too dangerous and they fear for the child's safety.

Position of travellers, Romany and Cinti

Special attention is given to travellers, migrants and refugees. These groups are difficult to reach. Family members have strong ties, rituals and customs. Mortality and morbidity figures of very young children show higher incidence and prevalence of infectious disease, accidents and poor health status due to nutritional disturbances due to iron (hypochromic anaemia) and vitamin D (rachitis) deficiency (Buszman et al 1995). From a study in Britain the Travelling Gypsies are generally well informed about interpretations of health and illness events. But the experiences of the travelling communities suggest that the cultural values of both the health care system and the health care professionals marginalises the specific needs of this particular group by failing to adapt. For instance, the mobility of lifestyle is incompatible with a service specifically designed for a settled population with a permanent address (Moreton 1995). Similar signals are present in other countries.

Position of migrants

International migration is complex[3]. With the influx of several millions of migrant workers and their families from both European and non-European countries, and growing numbers of asylum seekers and irregular migrants since the early 1980s, international migration has become an issue of major concern for Europe's policy makers and the public at large. Europe has become a de facto region of large-scale immigration (Paiva 1995). In many EU-countries there are migrants working and taken in as refugees from other European nations. Some migrants suffer from ailments that are not present in the indigenous population. In the past 15 years research has shown differences in health and disease between migrants' children and Dutch children. Apart from major socio-economic differences other factors are responsible for the health equalities found. For example: Mortality figures of Moroccan and Turkish children are 2.5-3 times higher than those of Dutch children. The main causes are perinatal problems, congenital malformations, accidents and drownings, infectious diseases of the respiratory tract and SIDS. Illnesses are also different in the area of infectious diseases, lactose-digestion and inherited diseases such as thalassasaemia and sickle-cell anaemia (Schulpen 1995).

Position of refugees

Refugee parents need safety and security, a friend, a neighbour, a non-professional or a professional to facilitate their transition, from past to present and from one culture to another. They need information about reactions to stress and information about how to cope. The experiences of refugee children and their families are characterised by long-term efforts to cope with the combined and interactive effects of traumatic events and cumulative stressors and to adjust to the stressful changes that are taking place at various levels. These developments mean that the basic ECCD Program needs to address multicultural issues, psychological and health problems. Refugee families have often lost their support system. Helping families to create a new support system network and utilise the resources within the family can be seen as an important step in the process of help. The informal support reduces the impact of stressors and facilitates coping with negative life events (Bala 1995).

ECCD-type programs

Most of the programs that we discussed dealt with infants. Some are dealing with toddlers aged 1.5 - 3 years. We will be talking about programs that deliver health and social support to vulnerable parents and very young children. Parents care about their children and want the best for them. They already know a great deal about child rearing. This knowledge is respected. Further information and support can help them to create an environment that will ensure positive child development. Our programs do not focus on parents with older children such as Home Start or HIPPY. They work mainly with young inexperienced parents. They are adapted, and share the same common roots. Because they are comprehensive and integrated programs there is an opportunity created to produce important health and social gains at the level of the child, the parents and the community (Meyers 1991). It extends its influence on the professional expertise, care delivery and the educational requirements of nurses. These programs aim to empower parents. Empowered parents may be able to influence their span of control so that their world becomes more manageable. A wide variety of inputs is required to support children's growth and development. An important thing is that all the inputs require someone to interact with the child. Very young children are not capable of obtaining what they need on their own. The role of adults in supporting children's learning is to provide them with opportunities to work with concrete objects, to make choices, explore things and ideas, experiment and discover. Children also need opportunities to interact with peers and adults in a safe environment that provides the child with security and acceptance.

Health and early child development[4]

From the moment of conception important developments occur that affect the brain, the physical body, and the chemistry of a child. These all have an impact on that child's ability to learn, to thrive, to grow and be healthy. The first 6 years of a child's life form the foundation for all later development. Developmental psychologists have demonstrated that in the early years a child develops all the basic brain and physiological structures upon which later growth and learning are dependent. Emotionally and socially, as well, the child develops many of the abilities upon which later social functioning is based. Attention to young children from the beginning can help to prevent later difficulties. Good nutrition, nurturing, mental stimulation and interactions for infants are the best preventive measure for avoiding developmental delays and disturbances. Physical, mental, social and emotional development and learning are inter-related. Progress in one area affects progress in the others. Therefore, we pay attention simultaneously to physical development (through health and nutrition), mental development (through education and stimulation), social-emotional development (providing affection, and opportunities for social participation), and spiritual development; a holistic and integral approach.

Given the importance of the environment in promoting children's learning, it is also possible to focus interventions on changing the child's environment. For example, increasing family income, upgrading health and enhancing the social and political milieu will affect children's growth and development. It is important that children have the opportunity to construct their own knowledge through exploration, interaction with materials and imitation of role models. This means that adults should use methods that fit with the child's growth pattern, not only in the cognitive area, but also in the affective, perceptual and motor areas. Activities should provide the child with an appropriate

developmental challenge. Development and learning occur as children interact with people and things in the environment. We stimulate activities which help parents to encourage, nurture, stimulate, talk to and play with their children. Children learn and develop better if they are actively involved. They learn in part through constructing their own knowledge. Children live within a context - family, community, culture - and their needs are most effectively addressed in relation to that context. Our programs are often linked with the well-baby clinics and statutory services. Sometimes they are even part of those statutory services and specially targeted at children in need. Support to the family and community can help children. Support to children can help the family and community. Support of early development yields rich benefits not only in immediate ways but also over time. All young children deserve to be cared for, nurtured and supported in their development.

Political issues

Working with families in deprived areas is based on a set of principles which are similar to those in the 'Health for All' strategy of the World Health Organization and the 'Primary Health Care' philosophy (WHO 1978;1985):

- *the empowerment of people and communities*
- *building on the strengths of individuals and communities*
- *the development of confidence and greater control over their own lives.*

These principles are the basis of the programs in Ireland, the Netherlands and United Kingdom. They are all programs in which mother themselves play the pivotal role. Experienced mothers, supporting, facilitating areas, stimulating other inexperienced mothers with some coaching by professionals.
Visiting mothers are usually influenced by experimental learning practices through their experiences in life (WHO 1993; Torkington, & Landers 1995). They have learned and built on their own experiences and developed their own self-confidence. They have thus empowered themselves. It seems reasonable to expect that the availability of our programs could facilitate maternal employment and productivity, especially away from home. Research results in Ireland, the UK and the Netherlands show indications that visiting mothers are progressing to paid employment or that they go back to school to continue with their education. Increasingly, mothers who received the program themselves wish to participate as a visiting mother when they reach the end of their involvement in the program. Or they start a support or self-help group looking after each other's children, which enables them to go back to part-time work outside their home. This would add to family income and thereby contribute to improve their child's life. The mothers indicate that their earnings increase the percentage of total family resources devoted to their children's needs.

Cost

Costs is an important issue. Relatively speaking most countries do not spend much money on preventative programs. Activities that have shown their worth are screening and inoculation programs in well baby-clinics. New innovative developmental and care programs still need to show their worth. That is difficult to achieve, especially when the effects need to be shown in a relatively short time span. There are major determinants of costs. These are: age at start, frequency, duration, ratio, staff qualifications, supervision and administration, and parents' involvement and community context. These program characteristics have the most influence on costs and are relatively easy to mandate or

regulate. Most often cost analysis is concerned with average or marginal cost per child rather than total cost of a program. Average cost per child (unit cost per child) is the total cost divided by the number of children served. Marginal cost per child is the addition to cost required to serve another child. When national efforts in preventative programs remain relatively modest, marginal costs could be substantially below average cost because there are significant fixed costs that can be spread over a larger number of children. In any event a focus on average or marginal costs requires the measurement of an important variable, the number of children served. At present information along these lines has not yet been presented in some of the existing programs. Our programs need to show their effects on health and welfare determinants. Additionally, they have to prove that they enhance existing statutory programs. In this way the cost-effectiveness of statutory childhood care and development programs is enhanced.

Vested (medical) interests are at stake. One way of dealing with this problem is providing comparable data between costs in existing programs and those of the innovative programs. The economic feasibility of alternative programs could then be assessed by the analysts and administrators. Unfortunately, there are as yet no cost-effectiveness studies or cost-benefit studies done on existing program components dealing with development and care. By reason of this the funding of ECCD programs is often additional, and on a subsidy-basis.

Valuing quality in early childhood services and research

Early childhood development programming is now viewed by research and professional bodies as the first and essential stage in the basic education process. There is a growing appreciation of the crucial importance of the child's earliest years, and the need to support and facilitate families and communities in their role of providing an environment supportive of the child's overall development. Facilitation is about believing from the beginning in people's ability to learn and grow, not just about learning techniques. Countries that succeed in mobilizing government, local authorities, communities and voluntary organisations in the care and education of very young children have been able to make an important contribution towards population information and the education of women. Very often these activities also encourage changes in behaviour and promote healthy lifestyles.

ECCD programs are evaluated internationally (Olds et all 1986; Olds & Kitzman 1990; Dunst & Trivette 1988). They have shown to be effective in countries where the starting point of the health and welfare of children was very low (Larson 1980). In Western Europe there are some immediate health gains to be got with the sort of programs we are providing (Johnson et all 1993; Barker & Anderson1988; Barker 1992). There are favourable outcomes around safety and the prevention of accidents. In Ireland and the UK gains have been recorded with the reduction of children taken into care and the reduced number of children suffering abuse. In the Netherlands these findings cannot be shown because the law prohibits a link with regional or national registrations or social security numbers. The national systematic reporting of child abuse cannot be used, as a national professional guideline for nurses and well-baby clinic teams has not been nationally implemented. Analysis of some determinants of health and welfare is however possible: nutrition, self-esteem of the mother, the perceived health status of the mother and her social network and use of child care facilities. Multi-centre research of programs which basically come from the same roots could be possible. This would be an exiting

prospect using the conceptual framework mentioned in figure 1.

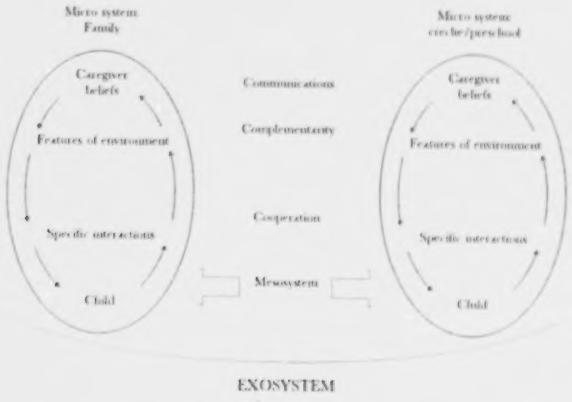

Figure 1. Family and pre-school as linked ecologies for child development

Figure 1 summarizes a conceptual framework for studies, combining an 'ecological' approach with the concept of 'developmental niche' (Woodhead 1996; Bronfenbrenner, 1979; Super & Harkness 1986). Children are depicted as growing up in the context of the micro-systems of family and of pre-school (or nursery). Within each micro-system, the impact of the environment is powerfully mediated by the beliefs and expectations of care-givers, as expressed through the extent and character of their specific interactions with children. The relationship between the micro-systems, in terms of shared or conflicting mutual beliefs of care-givers, as well as active points of contact, constitute the meso-system. Finally, although children's immediate experiences are directly shaped within the micro- and meso-systems, indirectly they are strongly influenced by wider forces, such as the employment patterns of parents (the exo-system) and by the overall economic and political situation (the macro-system).

In conclusion

Our programs will go some way to help the children in need. The strength of our programs lies in the combination of tackling health and socio-economic determinants, coupled with activities to empower women to take charge of their lives. This book may give some indications of the development of appropriate programs for children under the age of three. Children within this age group are relatively invisible. Yet, as research indicates, it is a very critical period in terms of health, nutrition and cognitive stimulation. The participants of this conference could help to bridge the gap in developing effective programs for infants, toddlers and their families. Hopefully we contribute to a decrease of socio-economic health differences and increase the score on major health indicators. We have to prove that these programs do contribute to give children an opportunity to develop to their highest potential.

Positioned side by side with the reduction of socio-economic health differences is training and educating adults. This is the other major focus of our programs. The programs are developed with the aid of experienced mothers themselves. The experienced mothers use experimental learning techniques to share their experiences and exchange information with the inexperienced mother. Both are actively involved and share the responsibility for their

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own learning. Many mothers have high levels of creativity, imagination and understanding of children's needs. The work experience as a mother is often not recognized. These experienced mothers are professionals in their own right. They have learned from life. They contribute towards quality assurance because their experiences and reports pinpoints inadequacies of existing services. Their experiences however, do not lead towards a formal recognition (certificate or partaking in policy decisions), and rarely do they get an opportunity to prepare others for the role as a visiting mother (Torkington & Landers 1995).

The dissemination of information about ECCD-programs is influenced by the attitude of policy makers. They want an effective program at affordable costs. A discussion is ongoing whether to pay experienced mothers, or to keep the program community based and working strictly with volunteers. The opponents of the strictly volunteer rule say that the activities undertaken are considered work, for which women are trained and then asked to participate for a minimal set of hours. These women exchange their time, skills and knowledge as a mother for a fee. If they are paid the activity can be counted as a first step to full employment and financial independence from state support.

Health, care and welfare are meeting each other in a fruitful coalition. But program development is not finished. International co-operation could lead to new opportunities to solve some of the problems which are encountered. Cost-effectiveness is an essential ingredient of a good ECCD-program. Our ECCD-programs have multiple targets (child, mother/parents and the community). They are individually geared home visiting programs. But it must be said, cost-effectiveness is a relative concept. An inexpensive program, in absolute costs, can actually be costly if it does not produce results in the eyes of policy makers. Human development is a continuous process. But the decision as to when to measure an effect is a difficult question. Usually short term effects are measured, but this then brings up the issue of sustainability. The appropriate evaluation instruments to measure progress in children of that tender age are not always available.

ECCD-programs which integrate a contextual approach with multiple goals and multiple targets, empowerment, shared goals, proper timing and cost-effectiveness can go a long way to change both the mother and the child. The primary challenge is to continue to explore ways in which partnerships can be developed between statutory and non-statutory agencies, without contributing to a sense of competition. There is a strong need for international co-operation for advancement on all fronts.

Notes

1 The focus of this book is serving children in need through the provision of innovative effective early childhood care and development (ECCD) programs. I have included an appendix which will give you some working definitions of used terms.

2 Consultative Group on Early Childhood Care and Development, *Meeting Basic Learning Needs*. UNICEF, 1990.

3 A degree of classification is useful for the purpose of discussion and analysis. For this purpose the classification used by the International Organization for Migration is included in appendix 1. They were taken from: Appleyard, R., *International Migration: Challenge For The Nineties*, Geneva, IOM, 1991 p. 22.

4 These texts are based on articles which are stored at the WWW-side on Internet; Presented by the Consultative Group on Early Childhood Care and Development.

5 The body of this text was taken from http/www.ecdgroup.com/eccd.html, presented by The Consultative Group on Early Childhood Care and Development. The authors used the following references in their text:

- Enhancing early child development: Alternative Program Strategies, C. Landers. A briefing note presented to the Workshop on Early Child Development UNICEF, Cairo October 9, 1990.
- International Early Childhood Care and Development: Where we stand and the Challenges we Face, Judith L. Evans, Secretariat, Consultative Group on Early Childhood Care and Development. Paper presented at the National Consultation on ECCD organized by the National Inter-agency Committee on Early Childhood Care and Development. November 11-12, 1994, Quezon City, Philippines.
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Appendix

1 Principles and definitions Early Childhood Care and Development (ECCD) Programs[3]
Children do not just grow in size. They develop, evolve, and mature, mastering ever more complex understandings of the people, objects and challenges in their environment. There is a general pattern or sequence for development that is true of all children. However, the rate, character, and quality of development vary from child to child. Culture influences development in different ways, and the goals for children differ from culture to culture.

2 Early Childhood Care and Development
ECCD refers not only to what is happening within the child, but also to the care that the child requires in order to thrive. For a child to develop and learn in a healthy and normal way, it is important not only to meet the basic needs for protection, food and health care, but also to meet the basic needs of interaction and stimulation, affection, security, and learning through exploration and discovery. ECCD activities are those that support young children appropriately and seek to strengthen the environments in which they live.

ECCD includes working with parents to strengthen parenting skills, working with siblings and other family members to recognize the specific developmental needs of younger children, working to provide or strengthen day care options, developing pre-schools and other early childhood education programs that address the child's needs in holistic ways, as well as striving to bolster the community in its economic, physical, and moral support of families and young children.

ECCD is a relatively new field and combines elements from the fields of early childhood education, infant stimulation, health and nutrition, community development, parent education, sociology, anthropology, child development, and economics. International ECCD arose from the recognition that these elements all interact within the life of a young child. If we want to support young children and help them to thrive, then we need to understand the many facets of their development, and also address the contexts in which they are living.

When discussing ECCD, it is important to have a common understanding of what is meant by the term. There are three parts to the phrase: *early childhood -- care -- and development.*

3 Early Childhood
As it is currently used internationally, *early childhood* is defined as the period of a child's life from conception to age eight. There are two reasons for including this age range within a definition of ECCD. This time frame is consistent with developmental psychology's view of the continuum of children's development. Children below the age of eight learn best when they have objects they can manipulate; when they have opportunities to explore the world around them; when they can experiment and learn from trial-and-error within a safe and stimulating environment. At about the age of nine they begin to view the world differently. They can manipulate ideas and learn concepts mentally and are less dependent on objects. Thus in terms of learning theory, the birth to age eight time period presents a developmental continuum.
The international definition of early childhood includes the early primary years (ages 6-8) because of the importance of the transition for children either from home or from a

pre- school program into the primary school. If pre-school programs for children are to be effective, there needs to be some interface between what happens in the pre-school and lower primary school. This does not mean that early childhood programs should become formal experiences for young children. Rather, there is a need for early primary teachers to become more aware of the experiences, skills and knowledge that children bring with them into the primary school if they have had an early childhood program experience.

4 Care

In the 1980's, the term *care* was added to the phrase early childhood development. This was in recognition of the fact that young children need care and nurturing. They need attention to their health and nutrition, their evolving emotional and social abilities, as well as their minds. The term care was chosen, rather than education, to move policy makers and program providers away from thinking exclusively in terms of pre-schooling.

5 Development and learning

Development is defined as the process of change in which the child comes to master more and more complex levels of moving, thinking, feeling and interacting with people and objects in the environment. Development involves both a gradual unfolding of biologically determined characteristics and the learning process. *Learning* is the process of acquiring knowledge, skills, habits and values through experience and experimentation, observation, reflection, and/or study and instruction. Both the child's physical growth (the child's health and nutrition history) and current health and nutritional status are crucial in the child's overall development. The child's current developmental status either facilitates or inhibits future learning. Learning is thus part of the development process (Myers 1992).

In many cases, the terms care and development also refer to the arrangements people make for their children. Day care, community or program development and child care are issues to look at in addressing the needs and supporting the healthy growth of young children.

6 Migrants and refugees

The word migrant is used in different settings and can describe a highly educated person working in an other country. But, very often people use the word migrant for someone who is foreign and is doing unskilled work or a recipient of welfare payments. The following categorisation is used:

- Permanent settlers come to Europe mostly through family reunification or marriage to nationals of European countries which do not usually define themselves as countries of permanent settlement.
- Temporary contract workers are normally skilled or semi-skilled workers who are expected to remain in the receiving country only for finite periods. The constituted the core of the migration process to Western Europe in the 1960's, most of it organized on a 'guestworker' basis by bilateral treaty. There exist also programs for seasonal workers, notably in Switzerland, and to a lesser extend in Germany, France, Austria and the United Kingdom.
- Temporary professional transients, persons with managerial or professional qualifications, dominate today's regular labour migration within and into Europe. Their growing movement reflects the global nature of world trade.

- Refugees leave their home countries for well founded fears of persecution and are recognized as such under the provisions of the 1951 UN Convention relating to the Status of Refugees and its 1967 Protocol.
- Asylum seekers are those who apply for refugee status. Western Europe received 560.000 and 693.000 asylum applications in 1991 and 1992 respectively, but only 319.000 in 1994 (Secretariat of the Intergovernmental Consultations 1995). These flows have introduced to Europe a great variety of new migrants, many of whom arrived without documents or with forgeries. Few of the many unsuccessful applicants are known to leave Europe.
- There is also the category of 'environmental refugees', which concerns movements of people who leave their home country due to natural or man-made disasters.

7 Private organization

The term private organization refers to non-profit organisations. They can vary in size, from a small parent or community group to large regional or national organisations.

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PART I: SETTING THE SCENE

2. THE MOTHERS VIEW ON COMMUNITY BASED PROGRAMS

Carolina Kleinjan-Rens

Introduction

In 1996 the organisers of the invitational conference in Amsterdam have asked me to share with you my experiences with the program. This contribution is based on that presentation. I am a mother of two children and I am working as a visiting mother for the Mothers inform Mothers program in Breda. I call it MIM for short. As a preparation for my original presentation I asked my colleague visiting mothers about their experiences. So I am more or less representing them. In my contribution I will be talking about the program from a mothers' perspective. I will answer the questions why I became a visiting mum and about the activities that we do in MIM.

Why becoming a visiting mum?

What motivated us to become a visiting mother? Last wednesday at our visiting mothers' meeting, I did ask that question in the group. They came up with the following answers:

- *In working in the program I helped other mothers to enjoy their baby.*
- *Through the program I give support, and make them (the inexperienced mothers) trust their own intuition.*
- *I was able to help young mothers to make social contacts.*
- *When I had my baby, I wanted to talk about it and someone listened: I like to give the same opportunity to other mothers.*
- *One of the visiting mothers said, 'I was too proud to avail of the program when I had my baby, but with hindsight I was sorry. Since then I learned that my experiences could be of help to young inexperienced mothers.*
- *I was insecure when I had my first baby and I wish now that this service was available at that time.*
- *I am happy to participate and be part of the program and the social network. It helped to raise my self-esteem.*
- *When I had my baby I was extremely lonely not withstanding my efforts to expand my circle of social contacts. Working in the program has changed that.*
- *It is nice to work with little children: It was for me a reason to start with my forth pregnancy.*
- *I started with the program because I felt trapped within the four walls of my house. And participating in the program made me go out and meet people.*
- *I felt that with working in the program I was very useful again.*

My motivation comes from past experience. I have benefited from the program and wanted to give something in return. My first contact with MIM was when my first child was born and I was asked to enter the program as a program-mother. At that time the program had just started in the Netherlands. It was a project which was still developing. Our baby was called 'number ten', for privacy reasons. After nine months my visiting mum stopped working in the program for personal reasons. In our last conversation she suggested to me, that I should become a visiting mother myself. At first I did not think I had enough experience to become a visiting mother. But, after giving birth to my second child, Annette, (the MIM co-ordinator) in Breda, phoned and asked *"Do you like to participate in the program as a visiting mum?"* I said yes. I wanted to help mothers in the same way that my visiting mother helped me. As a visiting mother I try to support other mothers in making their own decisions. Helping them to trust their own intuition and showing them how their child is developing are some of the other things we try to do.

Background information on the visiting mothers

The visiting mothers come from all levels of Dutch society. Our ages vary from 23 to 47 years of age. Some of us have part-time jobs. Some are single mothers, or foreign, and there are a few who have special experiences such as having twins, a premature baby, a baby with Down's syndrome, a cry-baby or suffering a postnatal depression.

What do we do?

Sometimes we give a little advice, but it is done in such a way that it looks like giving information. We never, ever, tell a mother how to raise her child. Often it is very important to listen. We give the mother space to tell her story.
The program-mothers know when we come to visit, they can talk about their child and their own experiences of being a mother. In those conversations we make use of the cartoons and the discussion paper. I use the discussion paper also as a kind of diary. In that way the mother and father can see what new things their baby has learned and done in the previous months.

We are also active with public relations. We are a very powerful and enthousiastic group of women. We belief in the program. We play a very important role in the presentation of the program to others and we also help with the recruitment of both new visiting and program-mothers. We do this by telling other mothers about our work as a volunteer. However, sometimes a potential program-mother may feel very clear and confident. This may keep this mother from entering the program. Sometimes a personal visit from the co-ordinator helps to explain the intention and aims of the program. We have also presented our work at conferences for nurses, because we like to show that our work is not a danger to their expertise.

Because of the relationship of trust, and very often friendship it can happen that a program-mother wants to talk about her own problems or personal experiences. It does not concern the relationship between mother and child, that relation is often very good, but it may be an experience which may influence her as a mother. It is up to the visiting mother whether she wants to talk or feels able to talk about these very private things. On occasion such a topic would be discussed with the co-ordinator after the visiting mother has obtained permission from the program mother. We usually refer a mother after a brief discussion to the appropriate services.

Some program-mothers have a lot of financial or health problems. Or they have troubles in finding or keeping their homes. They are very difficult to reach and do not always participate in the program. It is also very difficult to make appointments. There may be too many different problems present. The mother's first and primary concern is survival and not talking or discussing the developmental stages of her baby. In these circumstances it is difficult to start with the program, or to talk about the needs of children at all. The problems here and now are important for the mother. In these circumstances it is often the co-ordinator who will start the program instead of a visiting mother. She will try to help the mother who is looking for additional help and if necessary she will mediate to make the step towards other services.

Visiting mothers will often try to motivate a program-mother to take part in other activities. For example, an information-evening about child care, or neighbourhood activities that are organized for mother and child. Many mothers are not aware that these activities are carried out and where they take place. In Breda, for instance we organize, 'coffee mornings' in the community centres for young parents with children in the age of 0 to 4 years old. While the children engage in supervised play, the parents chat over a cup of coffee or tea. There are also singing and dancing activities organized and every week the children can make something that they can take home (colouring, painting etc.).

As a visiting mother you hear about activities that the program-mothers are interested in and would like to have organized in the neighbourhood. Sometimes this can lead to organising such an activity by MIM or the Kruisvereniging. For example, one of the topics was safety and we helped to organize a special evening about safety in and round the house for program-mothers.

Information on the program mothers

You have already heard where the program is carried out. When the program starts in a town, it is usually in a newly built or renovated part of the town. I visit young inexperienced mothers from all levels of the population. The largest group of mothers visited is, however, middle class. The number of mothers with another nationality is increasing. We visit mothers from the following countries: Bolivia, Britain, Colombia, Marocco, Spain, Sri Lanka, Turkey, the former republic of Yugoslavia, and Zaire. These mothers use the program also to get accustomed to the Dutch way of life. They can talk about their culture and ask questions about our way of living. The cartoons can help the foreign mother to make a choice between things from her own and the Dutch culture.

> An example:
> A mother from Sri Lanka discovered that she could ask openly for a room and some free time during her Dutch language-lessons for breast feeding her child. She discovered this fact during the discussion with her visiting mother which was stimulated by the breast feeding cartoon.

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Project
Moeders informeren moeders
V1
BORSTVOEDING
BORSTVOEDING IS HET MEEST NATUURLIJK
HET IS ALTIJD BIJ DE HAND EN
OP DE JUISTE TEMPERATUUR
AAN BORSTVOEDING MOET JE EVEN WENNEN,
MAAR ALS HET EENMAAL LUKT
BIJ BORSTVOEDING WEET JE NIET HOEVEEL JE KIND DRINKT, MAAR ALS HET HONGER HEEFT LAAT HET ZICH WEL HOREN
BORSTVOEDING KUNT GEVEN
KOLVEN EN EEN FLESJE LOSSEN DAT PROBLEEM OP
EEN SCHEMA VOOR DE BABY IS NIET NODIG

© Samenwerkingsproject Kruiswerkgroep Breda en Nederlands Instituut voor Zorg en Welzijn / N.I.Z.W.

Breast feeding cartoon

Number of program-mothers

The number of visits paid by visiting mothers vary from two to eight per month. Most visiting mothers visit two or three program-mothers. Normally we visit once a month, but sometimes we visit more frequently. Only a few of us have four mothers to visit. There is one visiting-mother who had eight mothers to visit. We think that visiting two or three program-mothers a month is acceptable. This is low, but many of us are involved with other activities. Some are active in their children's primary school, others are taking courses, or hold a part-time a job. Many of us run our own households and like to keep up our own social contacts.

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I normally visit three mothers a month. At the moment I have four program-mothers. For one of them it is really time to stop with the program, but we both think it is in her best interest to continue with the program for another month or two.

Support of the MIM co-ordinator and other visiting mothers

Our co-ordinator tries to visit all visiting mothers individually every month or 6 weeks. We call this 'the support visits'. In our individual discussions we may use the names of the mothers and their babies. When there are things we (visiting mothers) do not know how to handle, or when there are questions we do not know how to answer we call on our co-ordinator. Sometimes we hear negative stories from the program-mothers about the well-baby clinics. We sometimes pass this information on to Annette during these visits.

The visiting mothers come together every month with the co-ordinator as chairperson. In these meetings we use an agenda which is drawn up by the co-ordinator. She informs us about activities, changes and anything we need to know about the MIM-program. There are minutes taken so that absent mothers can be informed about what is going on. The last item on the agenda of every meeting is a session on sharing each other's experiences. For privacy reasons we use no names or any other specific description that may identify the particular program-mother in our meetings. We do discuss experiences if they are important for all of us. One of the topics of discussion recently was the following experience of one of the mothers. *A child was smacked by another child and she turned the other cheek (literally). And she was struck again. The program mother was worried about this behaviour and did not know how to react. She asked her visiting mother for her reaction.* We discussed this topic at length because it could happen to each of us and it deals with our own personal norms on violence.

For some visiting mothers the MIM-work showed them how to handle a situation of organising their time. Sometimes it is not possible to take your own children to the inexperienced mother. What do you do? The visiting mothers said: "*Your options are:*

- *take your child to the nursery. As a volunteer we may use the nursery which is run by the Kruisvereniging;*
- *ask your neighbour to baby-sit;*
- *make appointments when your own child(ren) are at school; or*
- *organize your visits in the evenings.*"

As a visiting mother you are forced to think about these situations, which is often similar to things you come across when you start or are planning on a paid job. In that way voluntary working in the program is like a trial period for yourself when you are thinking of going back to work or study. And some of my colleague visiting mothers did use their experiences from the program and gained enough self confidence to start looking for a paid job, or to go back to school.

3. THE COMMUNITY MOTHERS PROGRAMME IN DUBLIN

Brenda Molloy

Introduction

The Child Development Programme is an international Parent Support Programme in which Health Visitors or Public Health Nurses carry out structured home-visits to foster parenting skills and the mother's selfesteem.

In the Eastern Health Board a novel approach was developed by replacing the Public Health Nurse with an experienced mother from the same community and of similar social status as the client. This then became known as the Community Mothers Programme.

The Programme was evaluated in 1989 using a randomised controlled approach. This study, the first to use non professionals in a structured way, showed that the Programme is successful in achieving its aims of improved health care, nutrition and development of babies.

The success of the Community Mothers Programme raises important issues for health promotion in general: Should more lay people be involved in other areas of health promotion? If so to what extent should they be involved in the planning and organising of Programmes? What are the implications for professionals working in this area? Will they see lay involvement as a threat to their position? How can we build a harmonious partnership between professional and lay person? The above issues are important areas for consideration and reflection.

The community mothers programme

The Community Mothers Programme is a home visitation program for first and second time parents. The Programme is targeted at disadvantaged areas with large numbers of births. The criteria for area selection include housing type, social class, education and unemployment as derived from census and other data. The Programme operates under the guidance of a Family Development Nurse who is a specially trained Public Health Nurse seconded to this work. Each Family Development Nurse recruits, trains and supports approximately fifteen to twenty local volunteer mothers known as Community Mothers, who each in turn support between five and fifteen families. Most areas would be working with 120 families at any one time. The Community Mothers visit these parents on a monthly basis to offer support and to help develop the clients parenting skills and self confidence. The Programme focuses on health care, nutritional improvement and overall development.

Community Mothers visit parents in their own locality. The Family Development Nurse is informed of new mothers by the Public Health Nurse. Parental involvement is voluntary but the majority of those offered the programme do accept and complete the programme. In general the children on the programme are aged from new-born to one year of age with a percentage being visited into the second year. Nearly half of the parents are single, two-thirds are aged under 25 and a quarter younger than 20 years of age. Few of the mothers involved in the programme are in paid employment and unemployment is as high as 50% for the fathers of the children involved in the programme. Less than half of the mothers involved in the programme have any form of educational qualification.

Operation of the programme

The Community Mother visits the parent, in most cases the mother, for one hour each month by appointment. The visit is structured with a form to complete which reminds the Community Mother and parent of the key points, though the content is left to the parent. At each visit the Community Mother discusses with the parent the outcome of the previous months ideas, then gives out 3 or 4 carefully chosen illustrated cartoons (these discuss childrearing in a humorous way) appropriate to the child's developmental stage and discusses each one. Then a 24 hour recall of the mother's and child's diet is recorded, encouraging the mother to realise that her diet too is important. Any health problems that have occurred are discussed and recorded. The parent is asked what ideas she would like to try out in the following month. It is important that these suggestions come from the parent. Developmental progress is recorded in a card kept by the parent. This process serves to enable and empower the parent.

The Programme is concerned with overall development, health and nutrition. The parent is acknowledged as the expert with her own child. She is supported in achieving her own goals for her child. The parent is encouraged to believe in her own skills for parenting thus reducing her dependence on professionals.

This is achieved by:

- *Drawing out the potential of parents rather than giving advice and direction.*
- *Using a behavioral approach in which parents are encouraged to undertake agreed tasks.*
- *Using illustrated cartoons sequences to show the alternatives available to parents in coping with various child rearing problems.*

The visits are based on equality, with the Community Mother developing a relationship of empathy, trust, and mutual respect and integrity with the programme parent. The Community Mother relates to the parent as an 'ordinary mother' not as a mini-professional.

Through this relationship the Community Mother is able to help the parent develop an active role in the Programme and increase her understanding of child development. The Community Mother brings suggestions and information in the form of cartoons, sharing her experiences with the parent and encouraging her to solve her own problems, thus ultimately increasing her independence.

The Community Mother meets with the Family Development Nurse once a month for a review session. At this one-to-one session Programme work with families is discussed, problems identified and support given. Every two months the Community Mothers in an

area meet as a group. At these sessions common problems are discussed and ideas exchanged. There is also a skills development aspect to these meetings, for example, listening skills, problem solving, group facilitation. As the Programme has progressed these group sessions have become invaluable for introducing newly recruited Community Mothers to the work of the Programme.

The Family Development Nurses meet regularly to discuss and review progress and the operation of the Programme in their own area. They also meet with the Director both individually and in a group. The Programme is structured in such a way that on-going monitoring is simple and results can be analyzed and reviewed from time to time by all those involved in the Programme.

Selection and training of community mothers

Community Mothers are selected by Family Development Nurses by drawing on the knowledge and contacts of the local Public Health Nurse, or on her own contacts if she had previously worked in the area herself. As the Programme develops, Community Mothers themselves provide further contacts who may be suitable for recruitment. In time, some mothers who have been recipients of the Programme go on to become Community Mothers themselves.

Initial training of Community Mothers by the Family Development Nurse takes place over a four-week period with a training session once a week which lasts approximately one and a half hours. A long period of initial training is seen as undesirable because volunteers need to get started quickly to gain confidence in their ability to work with others. The aim of initial training is to build on the Community Mother's knowledge and skills and to familiarize her with the cartoon educational material.

All training is done in the Community Mother's own home. This is because some Community Mother recruits may initially lack confidence and they find it easier to build their confidence in this familiar setting. A further advantage of the home based approach is that it shifts the power base to favour the community rather than the profession.

The training covers the Programme history, the objectives and philosophy that govern it and a discussion of home visiting including its purpose and approach. During this training the nature of the relationship between the Community Mother and the Family Development Nurse is one of equality. The Family Development Nurse is an enabler and facilitator rather than a teacher. The line of communication between Family Development Nurse and Community Mother is horizontal rather than vertical. It is accepted that the Community Mother has a lot of knowledge and skills from rearing her own children so that the Family Development Nurse does not see herself as 'the expert' with a monopoly on knowledge.

Training and development of family development nurses

The role of the Family Development Nurse is influenced by 'Health for all by the year 2000' with its emphasis on self-care. It is based on concepts of partnership and empowerment, promoting participation of clients and individual and community self-reliance.

It is a move away from working for people to working with people. This involves a process of 'de-roling', that is, a move away from the bio-medical model of health, and it fosters in the Family Development Nurse a commitment to the development of appropriate skills, for example, listening, facilitation, participatory management and evaluation.

The training and education process for Family Development Nurses aims to help them become self-reliant, creative, self-motivating and self-managing, thus helping them reach their own goals and solve as far as possible their own problems. Each area takes full responsibility for its work. The basic principle is teamwork with people accountable to each other in the appropriate areas of work. A regular cycle of reflection and action ensures that there is an opportunity to celebrate successes and analyze critically the cause of mistakes and failures and to ensure common goals and values.

Evaluation of the Community Mothers Programme

The Programme was evaluated in 1989 using a randomised controlled approach. First-time mothers (232 in all) were randomly allocated to either receive the Programme or to act as a control group. Children in the Programme group were more likely to have received all of their primary immunisations, to be read to and read to daily and were exposed to more nursery rhymes than those in the control group. They were less likely to begin cows' milk before 26 weeks and to receive an inappropriate energy intake and inappropriate amounts of animal and non-animal protein, whole foods, vegetables, fruit and milk. Mothers in the Programme group had a better diet than controls and were less likely to feel tired, miserable and to want to stay indoors. The Programme is about the development of the child, both physically and mentally through the empowerment of the parent. It would appear from the evaluation that the development objective was achieved and that there was also an effect on the health status of the child.

A summative evaluation was carried out on the effect of the Programme on the Community Mothers in 1992. This study concluded that all the Community Mothers had been affected in some way in a positive manner from their involvement in the Programme through a process of human development that had contributed to mental and social well being. This had affected not only themselves but also their relationship with families. These benefits were related to the educational process within the Programme; their relationship with the participants, their increased status in their communities and the social milieu of the Program. Overall these benefits showed themselves from six months onwards.

In 1994 a descriptive study was undertaken of one Programme area. This independent evaluation was conducted by the Centre for Health Promotion Studies, University College, Galway. The study looked at what the involvement in the Programme had meant to parents, children and Community Mothers. The study concluded that the structured support that is given to Community Mothers from the health sector gave the Programme considerable benefits in organisational terms. Positive outcomes were recorded for parents, children and Community Mothers from their involvement in the Programme. The Programme was accompanied by high levels of satisfaction and recommendation by parents and Community Mothers demonstrated a high level of commitment to the Programme.

In 1995 a study was carried out, to see if the Community Mothers Programme could be extended successfully to the Travelling community. The results of the Programme for a Traveller sample of thirty nine Traveller mother and infant pairs, were compared with the results of the previous randomised trial of settled mothers. The study concluded that given the disadvantageous starting point of the Travelling community the results of the Programme for the group are encouraging, especially with regard to dietary habits, mothers' self-esteem and developmental stimulation of children.

On-going evaluation of the Programme helps clarify goals and facilitates ongoing planning. The Programme is structured in such a way that on-going evaluation is simple and results can be analyzed and reviewed from time to time by the Family Development Nurse and Community Mother.

Current status of the programme

The Programme is currently being delivered to over 1000 parents per year by 160 Community Mothers facilitated by 10 Family Development Nurses. The home visiting is central to the Programme, but out of this process of contact between the parents and Community Mothers one finds a growth in selfconfidence and skills development. By means of the empowerment process there have been many spin-off initiatives from the Programme. These include: Parent and Toddler Groups (14); Breastfeeding Support Groups (7); a Toy Library; an additional health information visit to families; a Programme for Travellers; Ante-Natal Visiting and Breastfeeding Support Visits.

Many of the Community Mothers have moved on to adult education Programmes or paid employment. In 1995 over one third of the Community Mothers who left the Program took up paid employment.

The future

The positive results found during the evaluation of the Community Mothers Programme has had a beneficial effect on the Programme itself. The recently published Irish health strategy document *'Shaping a healthier future: a strategy for effective healthcare in the 1990s'* (Department of Health, 1994) stresses the principle of equity and imposes an obligation on Health Boards to pay special attention to areas or population groups whose health status is below average. The Community Mothers Programme is mentioned in this document as a type of approach to this problem.

As a result there are plans to expand into new geographical areas in the immediate years ahead. A major challenge for the Programme in the future will be the capacity to respond openly and critically to new challenges and ideas.

Summary

The Community Mothers Programme is an innovative support intervention Programme involving lay people aimed at improving the quality of parenting during the first two years of life. It started formally in the Eastern Health Board, Dublin, in 1988 for parents of children living in working class communities. It involves experienced mothers who deliver a Programme focusing on health care, nutritional improvement and overall child development to new parents. Support, encouragement and guidance are used rather than

advice. The Programme was evaluated in 1989 using a randomised controlled approach and was found to be effective in terms of health, nutrition and developmental stimulation. It has since expanded to incorporate Breastfeeding Support, Parent and Toddler Groups and attention to the special needs of Travellers.

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4. EFFECTIVE STRATEGIES OF PSYCHOSOCIAL PREVENTION: A CONCEPTUAL ANALYSIS

Jo Hermanns

Current practices in the prevention of youth problems are directed at specific causes and processes in child rearing and child development, such as responsivity in parent-child interaction or cognitive stimulation. Professionals determine what is going wrong or what is lacking in a family and introduce correcting or compensating methods. This approach is typically named 'early intervention'. Professionals intervene in child development and child rearing to accomplish goals that parents and children can not accomplish by themselves. In this contribution, the position is taken that not early intervention but family support is a more promising approach. Departing from an analysis of child rearing as a self-regulatory system it is proposed that preventive efforts should not be addressed to factors and processes within the child rearing system, but would seek to create conditions in which the self-regulatory processes of the child rearing system could gain a new momentum to help parents and children to solve their own problems.

A call for psychosocial prevention

Youth problems are a matter of growing concern in most modern societies. Substantial proportions of the child and adolescent population are in special care, in special education or in special institutions. In the Netherlands, for example, it is estimated that about ten to fifteen percent of the population between 0 and 18 years have serious and complex psycho-social problems. These psycho-social problems manifest themselves in school dropout, delinquency, psychopathology, addiction or street-life. Figures on juvenile delinquency show a steady increase in the last thirty years. Particularly alarming is the fact that young people are often engaged in violent crimes; since 1990 violent crime has increased by more than fifty percent. In the Netherlands we register about 7000 streetchildren annually, several hundreds of whom are permanently homeless. Fortunately, the use of hard drugs has not increased, but alcohol abuse and gambling are spreading (Ministry of WVC, 1993; Beker & Merens, 1994). These figures have caused great concern in a society which strives towards a reasonable level of quality of life for all of its citizens. This concern is increased by the growing evidence that once children get into serious problems, the effectiveness of cure, treatment and guidance activities seems to be alarmingly low. It can thus be appreciated that a policy that is aimed at effective problem prevention receives ample support. Let us now see how this line of thought is brought into practice and what the effects are.

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Current practice in psycho-social prevention

Current practice in psycho-social prevention and intervention in the Netherlands is based on a paradigm borrowed from the field of health promotion. Workers in this field look at prevention as a variation on the theme of treatment. In this paradigm a health problem is analyzed in specific causes and facilitating conditions, such as viruses, toxic substances, eating habits, lack of exercise and so on. A program is then constructed to deal with these causes and conditions. These programs comprise, for example, immunisation of individuals at risk, health education programs, programs directed at behaviour modification or legal prohibition of toxic chemicals. A typical and recent example of efforts to prevent health hazards in young children is the investigation of sudden infant death syndrome.

> **Sudden infant death syndrome (SIDS)**
> Scientific and empirical research into SIDS produces a number of causes and conditions that are proven to be correlated with the problem. In recent years a number of etiological factors came to the fore:
> - too high a temperature in the cradle;
> - the sleeping position of the child (prone or backwards/ on the side) and, most recently;
> - smoking habits of parents during the pregnancy and after the birth in the presence of the child.
>
> Primary health care agencies responded to the discovery of each new finding. A nation wide health educational campaign was started aimed at all parents with small children, using national and local radio, television and newspapers. The parents were also informed during their regular visits to the well-baby clinics. The outcome of this campaign was a substantial decrease of sudden infant deaths.

The prevention model which has been successful in health care is used also in the field of psycho-social youth problems. The process approach, which consists of analysis of problem - determination of cause - program design - program evaluation, is proposed in almost all international and Dutch publications in this field.
In 'diagnosing the problem', a variety of more or less empirically validated causes of youth problems (in terms of educational and psycho-social problems) has been identified. These are:

- a lack of responsivity and sensitivity in early parent-child interactions;
- a lack of cognitive stimulation;
- type of parental teaching style;
- a lack of playing-opportunities in the family or in the community;
- rewarding of desired behaviour and punishment of undesired behaviour and
- a lack of co-ordinated action in the case of beginning juvenile offenders.

A wide array of programs has been designed since the early 1970s to deal with the supposed causes, but evaluation of effects is, unfortunately, not a common practice. The results of evaluations which took place in controlled studies had great difficulty in showing effects. Recent examples are the Dutch variations on the Hippy theme (Opstap, Instapje, Opstapje). Other forms of programmatic early intervention activities also failed to show substantial effects on child development. We do not seem to make much progress in the prevention of any of the youth problems at all. To address this I will make some remarks on the process of child rearing which is the target of our preventive efforts.

Child rearing processes

It is nearly impossible to describe even approximately all implications of child rearing and what occurs between parents and their child. However, one or two general points can be mentioned.

1 transactional process

Among workers in the field of research on child development and developmental psychopathology there is a general agreement that child rearing is a transactional process. Within this process there is an ongoing interaction between children and educators characterised by mutual influencing. Clearly, parents have an active contribution in child rearing. However, from the very beginning, the child actively influences and guides its own child rearing environment. Development is interpreted as a transactional process in which children and parents mutually influence each other's development. Child development in this way becomes a very complex process. From this perspective of development child rearing is not just seen as a package of information or behavioural training given to the child by his/her educator.

2 reciprocal process

Child rearing is seen as a subtle process requiring a great deal of attention and energy rather than knowledge or specific skills. This attention is required from the parents, in order to pick up questions and signals sent by the child and then finding the right answers for them. But attention and energy is also required from the child in order to participate in the process, with giving understandable signals, reacting to the signals sent and the answers given by the adults. The process of child rearing seems to have built-in properties that facilitate both a satisfactory process and outcome. In most cases child rearing is a reciprocal process which results in independent humans who are living in reasonable harmony with their social environment and with themselves. In turn they themselves are also able to participate in child rearing activities as parents.

After an extensive empirical study of child rearing in the Netherlands (Rispens, Hermanns & Meeus, 1996) the authors concluded that the average Dutch parents are supportive and sensitive to the behaviour and needs of children. They exert predominantly an authoritative style of controlling the behaviour of children, and only a minority of families is characterised by chaotic or strict authoritarian parenting. In most situations, even when they are not specially trained or professionally guided, parents seem to find the right answers for the developmental questions about their child, and most children are able to make good use of a wide variety of child rearing behaviours for their own development. One could almost speak of a certain degree of sociobiological pre-programming involving both parents and child, otherwise it cannot be explained how such an intricate process as child rearing can take place at all.

3 child rearing as a social system

Child rearing, seen as a social system, has a certain degree of self adjustment and resilience in the sense that the system corrects itself when necessary. Without special help most children and adults seem to accomplish the developmental tasks that are required in our society. This process functions under very different circumstances. An estimated ninety percent of all children grow up into healthy and well adjusted adults and in terms of our model they are able to participate in several social systems.

Risk factors

In spite of its power and resilience the reality is, however, that for a large number of parents and children the child rearing process is still strained and problematic. Factors which threaten the self-regulatory power of the child rearing process are called risk factors. According to an extensive representative study into the living conditions of Dutch children (Peeters & Woldringh, 1993), only a few children (approximately ten percent) do not find themselves confronted with one or more risk factors such as:

- discordant relationships between their parents
- physical punishment and practically no rewards from their parents
- emotionally uninvolved child rearing styles
- being bullied in school or other school problems
- having a difficult temperament, or chronic illnesses.

Risk factors can be found in the genetic make up of the child, in characteristics of the parents and in the context of the child's family. Sometimes the participation of children in the process stagnates and parents lose their grip. Obviously the self-regulatory forces can sometimes become profoundly unsettled.

child centred risk factors

The factors in the child are often related to the temperament of the child, an acquired individual behaviour and reaction style, his or her 'personality' or other characteristics which may cause individual differences in the interaction with its environment. A number of characteristics of the child are known to complicate or aggravate the interaction of the child with its social environment. In some development disturbances, the sensitivity and responsiveness of the parents can be optimal, but the signals sent by the child and its initiatives can be so vague or disturbed that a mutual interaction is endangered. Children can disturb the child rearing process by not reacting to their parents' initiatives, by reacting in an inexplicable way to these initiatives, by showing interaction initiatives that do not fit the intuitive expectations of the parents, or by showing inexplicable counteractions to the parents' reactions. Risk factors studied in this connection are, for example, a 'difficult' temperament, irritable behaviour of the child, difficult to interpret behaviour as a result of premature birth or early deprivation, and inconsolable crying. Prenatal exposure to substances like cocaine, heroine or alcohol can also cause comparable and serious problems in parent child interactions.

parent centred risk factors

A second group of risk factors is related to personality characteristics and skills of the parents. Problems arise when parents fail to understand what the 'expectations' of their child are, when they cannot pick up certain signals, are not responsive, or react in an unpredictable, and, for the child, an inexplicable way. An almost endless list of conditions which endanger parents participation in the child rearing interaction can be made up. To name a few documented risks: personality disorders such as depression and psychosis, substance use and addiction, reactions to life crises such as loss of a loved one or divorce, can all sometimes play a role.

socio-economic status (SES)

In the context of the living conditions and environment of a family a number of risk factors can be identified. Probably the most widely used variable in behavioural and social research is socio-economic status. It is routinely recorded in almost every study. Low SES

is probably the most investigated risk factor. This choice is rewarding for most researchers, because negative effects of low SES are found on practically every child-development measure. SES-classification probably yields such striking results as a risk factor because it stands for a collection of risk factors such as low income, low levels of education, unemployment, bad housing, feelings of powerlessness and superfluousness and chronic stress.

Thus far, this analysis seems to support the programmatic prevention of youth problems within the traditional prevention model. It is possible to isolate a large number of factors which threaten child rearing and child development. What is then more practical than trying to change those factors?

Effects of risks: the concept of risk accumulation

A few decades ago researchers hoped by finding risk factors they would be able to delineate 'at-risk' groups and consequently would be able to design programs to improve the prognoses of these groups. This hope turned out to be futile. Further study brought up an important conclusion. The effect of the risk factors is not determined by its specific content or severity, but mainly by their number and by the burden they cumulatively impose, on the family. "*Although causal models have been sought in which singular variables uniquely determine aspects of child behaviour, a series of studies in a variety of domains have found that, except at the extremes of biological dysfunction, it is the number rather than the nature of risk factors that are the best determinants of outcome*". (Sameroff & Fiese 1990, p.121) An accumulation of various risk problems is necessary to unsettle the process of child rearing and I will present three well known studies to clarify this point.

Rutter (1978) examined the effects of six different risk factors present in various families on the development of psychical and behavioural problems by the child. The families participating in the study lived in impoverished neighbourhoods of London. The risk factors studied were: inter-parental conflict, low income, living in inadequate housing conditions, maternal psychological problems, criminal behaviour by the father and temporary residence of the child outside the family.
Each individual factor in itself had a weak or no correlation with the mentioned problems. The presence of two factors in the same family tripled the risk, and the presence of four or more factors increased tenfold the risk of psychical and behavioural problems in the child.

Sameroff and colleagues report on longitudinal data from the Rochester Longitudinal Study (Sameroff, 1985; Sameroff, Seifer, Baldwin & Baldwin, 1993). In this study the following eleven risk factors were involved: chronical nature of maternal mental health problems, maternal anxiety, rigidity in parental perspective, a lack of spontaneous positive interaction in infancy, low occupational status of head of household, low levels of maternal education, disadvantaged minority status, lack of family support, stressful life events and single parenthood. Individual stress factors were not connected with IQ at ages 4 and 13 years nor with social adaptation of the child in kindergarten. The number of stress factors in itself however, was decisive. The more risk factors were noticed, the lower seemed to be the IQ and the more problems in adaptation in the school the child seemed to have. The difference between children with zero and with 8 risks was 30 IQ points at age 4 and at age 13.

Garbarino and Kostelny (1996) tested the risk accumulation model in quite a different context. One hundred and fifty Palestinian children between six and fifteen years of age participated in a study which examined the combined effects of several forms of political violence:

- witnessing a violent event related to the Palistinian uprising (Intifada),
- Intifada related injury to the child,
- Intifada related arrest of a family member,

in combination with a number of family risks:

- violent acts of the mother directed at the child,
- physical violence of the father directed at the mother,
- verbal aggression between spouses,
- maternal depression,
- experienced parenting stress,
- physical violence in the family directed at the child by someone other than the mother.

In addition, the community context - like crowded living conditions, educational and occupational level of the father - gender and age were included in the analysis.
As an outcome variable mothers completed the Child Behaviour Checklist (CBCL) and the data on the 'Total Problem Scale' was reported. The relationship between the number of risk factors and the scores on the CBCL was almost linear. At a level of any combination of four risk factors the CBCL scores reached the clinical level i.e. that psychopathology is considered to be evident.
An important conclusion from this research is that child rearing is seriously in danger when families and children are confronted with an accumulation of risks. The content of specific risk factors seems to be less important than the sheer number of them.

This analysis of the origins of youth problems causes serious problems for the programmatic prevention model. The traditional model of looking at specific cause-event chains is not easily applicable. But the situation is even more complicated than that.

Individual resiliency and protective factors

In the last decade some attention has been given to the so called 'protective factors' (Garmezy 1985a and 1985b, Groenendaal, 1994) or resilience (Masten 1989, Werner 1993). The concepts of resilience or protective factors are used to explain the resistance of some youth and their families (those who do not show evidence of problems) to stress and adversities that result from risk factors. Resilience refers to an individual capacity to reach a successful adaptation in spite of risks and adversity (Masten 1995). Protective factors are generally defined as buffering factors in the child or its social context (Yoshikawa 1994). Resilience is taken to be a protective factor at an individual level.

The study of protective factors is interesting within the framework of this contribution. Earlier child rearing was seen as a process with forces which promote resilience and self-adjustment. Study of the nature and operation of protective factors as they are found in 'real life' might give insight to these processes of self regulation. Strengthening or compensating for these protective factors could be a new pathway to prevention and of early intervention in youth problems. The study of children and families who succeed in coping with risks might give clues to help other families to succeed likewise. The research literature on protective factors has a far more limited tradition and is much smaller than

the literature on risk factors. Reviews by Masten (1995) and Groenendaal (1994) lead to short lists of empirically validated protective factors, such as: humour, high intelligence, competence or ego-resilience (a personality trait-like characteristic), supportive parenting, having friends, social support from outside the family, feelings of self-efficacy, membership of a religious group, high SES, high quality schooling.
There is one specific group of protective factors which has a more sound basis in research and these factors will be discussed in the next section under the denominator 'social support'.

Social support as protective factor

The phenomenon of social support has brought about a rich research tradition in clinical and social psychology. Until recently the influence of social support did not draw much attention within child development research projects. Though numerous subdivisions of social support are used the most commonly used is the triad of emotional support, informational support and instrumental support.

In recent years a small number of studies investigated effects of social support experienced by families as a buffering factor for child and adolescent development. Turner and Avison (1985) examined 293 mothers of young children from the general population and 78 mothers who received services by reason of reported neglect or abuse of their children. The authors conclude that " *..social support, as experienced or perceived by the individual, effectively distinguishes among women who vary in their adaptation in the parenting role*". Another group of 102 neglectful parents of low SES (with a verified report to child protection services) was studied by Gaudin, Polansky, Kilpatrick and Shilton (1993). This group was compared to a matched control of 103 non-neglecting families. Neglecting parents reported more life stress, greater depression and loneliness and weaker social supports. A large scale study in this field was performed by Hashima and Amato (1994). In a group of 1035 parents they found that punitive parental behaviour (hitting and yelling) was negatively related to a number of measures of social support available for the parents themselves. Supportive parental behaviour (praising and hugging the child) was positively related to social support available for the parents themselves. Three different types of social support were examined:

- respondent's perception of social support: the answers to questions like, 'who would you call if you needed help in the middle of the night';
- social activities: the number of social evenings and recreational activities the respondents engaged in, and
- receipt of help: from how many people did the respondents receive emotional or instrumental help in a given month?

The results were generally in the expected direction: more social support was correlated with less punitive and more supportive parental behaviour. If the 'received help' was analyzed in more detail, it appeared that help in the domain of care-taking and child rearing was the key factor. The frequency of social activities was not related to parental behaviour, suggesting that a large social network is not always the same as a supportive network.

A number of studies can be mentioned that not only looked at the relationship between social support and parenting, but also examined (direct and indirect) effects on child behaviour and development.

An in-depth study of maternal support networks, maternal cognitions and attributions, the social development of the child and the cognitive development of the child (Melson, Ladd & Hsu 1993) yielded interesting results in a sample of 69 middle class mothers and their pre-school children. Maternal support networks were examined with the Social Network List, which assesses social network size and the Social Support Questionnaire measuring satisfaction with various aspects of social support. Both measures of social support were directly related to the child's cognitive development (IQ). They predicted also, mediated by maternal perceptions and cognitions, social skills of the child as measured by peer acceptance reported by the teacher of the child.

A Dutch study showing buffering effects of social support is described by Hermanns and Bax (1991) in a follow-up study of 100 children who visited a centre for day treatment due to behavioural and developmental problems. Two years after dismissal from the centre, at a mean age of 7 years, the families completed a number of questionnaires. Almost half of the children appeared to be doing quite well. The other half were doing less fine: there was a reappearance of developmental problems, leading to placement in special schools and behavioural problems in the family as reported by the parents. The two groups were compared on several variables and it was only in the social support system of the families that significant differences were found. The social network around the families in which the problems had reappeared was fifty percent smaller than the one around the other families. In the parents' perception, their network was giving them less support in difficult situations, as measured by an inventory of experienced support in the occurrence of negatively experienced life events. Within the family, the parents in the problem group experienced less support from their partner. The parents of the group of children who did not experience a relapse, reported more social support and more satisfying social support.

This section on social support as a protective factor shows that in the domain of parenting and child development, social support for parents can have positive effects on parenting behaviour and consequently child development. Social support for families seems to be an effective factor in fostering and promoting child development and buffering the adversities of risks.

Current practices in psycho-social prevention reconsidered

Most of the research on the prevention of youth problems is dominated by the concentration on factors within the microsystems of child rearing. Current practice, as inspired by this research, thus tries to deal with a variety of individual and specific risk factors. As mentioned earlier, a classical prevention paradigm is used in which 'causes' are determined and programs are designed to change the causal chains. This means that current prevention practice tries in most cases a systematically and programmed approach to change behaviour of parents or children. This is accomplished by a variety of teaching and learning techniques. I only mention a few, but there are more methods such as explaining, modelling, video-feedback or instruction. Parents are trained to be more responsive, to be more stimulating, to play and talk more with their child, to use more stimulating toys, to deal with the difficult temperament of their child more appropriately, to communicate in a more democratic way, to use more effective methods of disciplining and so on. The term 'early intervention' seems to be well chosen. Professionals 'intervene' in parenting and child behaviour to make up for deficits in the system. Departing from

the explanatory analysis of child rearing as a self regulating process, a different strategy can be thought of. This strategy would not address the factors themselves and the processes within the child rearing system, but it would seek to create conditions in which the self-regulating processes of the child rearing system could gain a new momentum to solve its own problems. This strategy would lean heavily on the strengthening and amplifying of protective factors such as social support. It is counter-intuitive in the sense that it does not deal directly with problems within the family which in the eyes of the researcher / professional obviously are obviously detrimental to the development of the child, but instead it tries to convey to the family that they are doing well, and that they deserve esteem and support.

Not much is known yet about protective factors. However, research into the protective operation of social support, gives important clues about potential effective strategies for prevention. Learning from 'common real life prevention' one might develop more organized and professional versions of protection by social support. This could be done either by intentionally and systematically strengthening informal social support systems around families, or by delivering social support in a professionally organized manner. Though it is not the intention of this contribution to describe concrete methods of prevention, some general remarks can be made about the nature of family support. Extrapolating from the phenomenon of social support, family support must contain the same elements as social support.

Family support:

- *emotional support: giving the parents the opportunity to express their emotions without any critique or condemnation;*
- *informational support: helping parents to get insight into their situation, or answering questions about child development and the specific characteristics of the child, and*
- *instrumental support: helping parents solve day to day problems, organising day care.*

Using the powerful forces of family support, new pathways to prevention of youth problems can be discovered. I am convinced that the future of working with disadvantaged families and children lies not in the medical prevention model but in the contextual family support model. The effective strategy is not in teaching people how to behave, but rather, in supporting them so that they can solve their own problems in their own way.

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5. COMMUNITY-BASED EARLY CHILDHOOD DEVELOPMENT: WIDER IMPLICATIONS OF THE NEW MOVEMENT

Walter Barker

A new form of community support for parents has been developing during the past decade. It is based on the principles of parent empowerment, using skilled home-visiting strategies. Its empowerment principles and strategies were introduced with an earlier professionally-run program, using health visitors (public health nurses) as the home visitors. However that program was radically modified in Dublin in the mid-1980s, with experienced mothers from the community becoming the home visitors. The Dublin program is now the biggest of its kind in the world. Subsequently the Community Mothers Program has spread to other centres in Ireland, to a number of areas in the United Kingdom, to the Netherlands and most recently to Perth in Australia. Other community-based parenting projects are also under way world-wide. The existence of these initiatives has raised major questions about the nature of parent support services in the community:

- what is their vision, philosophy and characteristics?
- how are the programs to remain true to their ideals?
- what are the barriers to realisation?
- how should such programs be monitored?
- what are their implications for communities' involvement in their own development and for the widening role of women and men in that context?

These and related questions are explored in this study.

The Community Mothers Program and other programs focused on community-based early childhood development offer a hopeful vision for the future. They are concerned with restoring power to the community and reducing excessive control by the state, by professionals and others over people's daily lives. They are also concerned with reaching back to our roots in holistic care, an approach which differs fundamentally from the materialistic approaches to caring, curing and life itself.

This vision goes far beyond the struggle to develop community mother and other programs in which we are all involved. While we work to embed our programs in the reality of state and community acceptance and support, we need to remain aware that there is also a much wider agenda to which we can ultimately aspire. The existence of that underlying agenda may be part of the reason why it is so hard to realise our seemingly simple goals. The competing power bases of society do not welcome a new

competitor which does not share their hierarchical perceptions and practices, and which inevitably will come to threaten existing power bases. We need to focus especially on three issues:

- *the philosophy and basis of community-based early childhood programs;*
- *the characteristics of such programs;*
- *their aims and the monitoring of their achievements.*

What is set out here are the ideals to which we might aspire. Few if any existing programs could claim to meet all those ideals.

Philosophical basis

The philosophical basis is or should be that:

1 *these programs are focused primarily on the total parenting role, rather than taking only the perspective of child care and child stimulation; they are rooted in the community, not in state or other non-community institutions;*

2 *while such programs utilise and co-operate with state and other outside agencies, which need to assist in their initiation, they should ultimately be controlled by their own communities;*

3 *the state and other resource agencies should continue to fulfil a monitoring role on behalf of the wider society; this could become a source of potential tension but is also a guarantee of quality, a role which has to be accepted by program workers and dealt with constructively;*

4 *the programs should be targeted mainly but not exclusively on those communities which face higher levels of social, economic and educational disadvantage; and finally, most important of all,*

5 *the programs should be empowering in their essence, rather than supporting the status quo in which the powerful dispense charity to the disempowered.*

Characteristics

The characteristics of such programs are many. They could include a variety of forms, all geared towards the creation of structures which reflect the unique elements in the communities they serve. These structures should:

- encourage co-operative endeavour without abandoning the key role of committed leadership;
- provide permanent in-service training undertaken by the programs themselves, with some regular fresh input from outsiders;
- develop the program's own leaders from within the local communities, with professional or other program initiators moving deliberately and according to schedule into a subordinate, supporting role;
- monitor the work and achievements of the program on an ongoing basis, with this monitoring being undertaken regularly by program workers and at intervals by outsiders appointed jointly by funding agencies and communities;
- stimulate equality of opportunity as an expressed goal of the programs, guaranteeing to social, ethnic, gender, religious and other community minorities a share in the benefits and the running of the programs;

- restrict organisational hierarchies to the minimum necessary for effective operation of the programs - in other words, as full a delegation of responsibilities as is possible without threatening the basic goals and,
- ensuring that all families and individuals within the community get the chance, at intervals, to voice their opinions on the policy, strategies and administration of the programs.

Everybody get the chance to voice their opinions (photograph Clementine Sandison)

Aims and monitoring achievements

The aims and monitoring of the programs are an essential guarantee to outsiders as well as to those involved that there are identifiable goals, and that the extent to which these goals are achieved is being regularly monitored. To some program staff this may seem to be a restriction on their commitment and ceaseless activity on behalf of their programs. In reality it is a form of insurance policy for the funding agencies and the community, as it will tell them whether the invested resources are being used adequately or negligently. It is no longer sufficient for program workers to assure the outside world that since they are highly committed and idealistic, what they are doing must be a good thing. There are however some key principles which need to be observed in setting goals and monitoring the programs. I will mention six:

1 The goals which program organisers set for themselves should be achievable and defined at both the conceptual and practical levels. Neither can be justified in isolation. The process by which program goals are achieved should be a key element in any monitoring. The description of what is done and why it is done is essential not only for the understanding of outsiders but also to aid program workers in conceptualising the what and why of their own actions.

2 The development of programs should in the course of time involve the local communities in specifying the goals they would like to see achieved.

3 The monitoring of programs should be based primarily on action research, to take into account the nature of community-based programs. It should, as a matter of principle, involve program workers as part of the team planning and undertaking the research, with a right to question the conclusions.

4 Double blind trials and other techniques of narrowly circumscribed and questionable validity are not appropriate, although this does not rule out the use of rigorous methods which may include an element of random sampling. The monitoring methods used should be both quantitative and qualitative. Each form can then support or challenge the other. A significant part of the monitoring should, as far as possible, also involve the communities and program staff themselves in what is known as co-operative inquiry research, to encourage people to look honestly at their effectiveness.

5 The widespread dissemination of monitoring reports is essential if programs are to survive and expand; this is not only to inform those providing the resources but also to aid in the creation of a wider societal consensus about the development of such programs in other areas.

6 Monitoring studies undertaken primarily or exclusively by outsiders are as open to bias as are studies undertaken exclusively by those involved in the programs.

Barriers to realisation

Anyone who has worked within early childhood community programs will know that there are many ifs and buts in what has been said above. We can look at some real problems which I will illustrate with the following questions.

- How can one have a genuine community-based program when a local community is alienated from the wider society. They are struggling to survive, and are well versed in conforming to professional expectations in order to extract financial or service support.
- How can one hope to build effective community leadership in the many societies where the achievement of a proper job often means that more resourceful families leave the community for a more advantaged neighbourhood?
- What happens when delegation of responsibilities to program workers leads to the creation of competing elites which in turn can paralyse the program or make its work ineffective?
- How does one cope with the kinds of community rivalries which find their expression in battles over control of local programs, given that such rivalries are often bred by poverty and the struggle for limited jobs and limited resources?
- How can one deal with health, educational and other professionals who feel threatened by the development of alternative community power bases. This can be a particular problem especially in situations where the more power that professionals already have over family life and parenting, the more resistant to change they tend to be?
- How should communities respond to the demands of outside research organisations which are willing to invest money in developing short-term professionally controlled programs, with little hope of continued funding and no real community involvement, in order to achieve prestige and publications for the researchers?
- How does one respond to academic research which professes to show that a program

which communities see as empowering and bringing about progress, does not meet the researchers' criteria for performance and thus cannot justify the money spent on running that program?

These and many other questions can be asked about the ideals set out earlier. They are among the challenges which program workers need to deal with when developing and managing new initiatives aimed at family and community empowerment. When programs die it is not usually because of a lack of vision or enthusiasm but rather because of the kinds of human and organisational problems mentioned above.

Some other program priorities

There are four particular issues which are interwoven with the problems described earlier. They all have an impact on the development of community-based early childhood programs. One could of course select many other issues which have an impact on program development. But these four issues are of central importance.

1 Families are at the heart of community. How they are to function and develop is of critical importance to the future of society itself.

2 For families with young children, health issues can be matters of life and death. Throughout the world most families believe their only solution to health problems is to seek expensive medical help. The importance to health of life style, nutrition and simpler alternative remedies is seldom recognized.

3 Women's right to choose is fundamental to family development in the modern world, if women are to play their vital part not only in the home but also in formulating the policies which determine the direction of the wider society.

4 What one might term the missing factor needs to be reintegrated into society; the role of men within the family and in the community will have to be re-thought because their contribution to social stability is as critical as women's.

Each of these issues is discussed in more depth below.

A. The stark choice faced by families in the future

Developments in all the major industrialised societies are pointing at the increasing trend towards social policies in which professionals are trained to be the guides and mentors of family life and child-rearing. This well-intentioned extensive professional involvement is leading inevitably to professional control. We have not yet reached the stage of professionals controlling women's rights to bear children. But there has been enough speculation to suggest that this is a real possibility, moving towards state control over the family as described by George Orwell. Already we have compulsory caesareans in the UK, 'preventive imprisonment' of pregnant drug addicts in the USA, and compulsory abortions in some East European countries and China, as forerunners of what is to come.

The alternative is for communities to claw back the controls which have been taken away from them. The absence of an extended family does not do away with the fact that families exist within communities, however alienated some of them may be. Given

encouragement and support, such communities can slowly awaken to an awareness that they can have a monitoring and supporting role for the families living there. The ways in which this is to be achieved have yet to be developed, but already there are some encouraging new strategies. Examples are tenants' associations being funded to maintain their community's housing, credit unions encouraging families and individuals to save with and borrow from the community and 'swaps' in which people exchange work with each other, with no payment of money. There is also state funding for deprived communities to enable them to employ their own doctors and other health care staff. A further step would be for communities to set up democratically chosen family support movements which could take over the current professional monitoring and guidance role. The local movements would not only have more credibility with families in their own communities, but would also be in a far stronger position to challenge ill practice, including child abuse. They could do this because they would not be seen as aliens imposing alien values, but as the community asserting its own values. Local checks and balances against misuse of such a system would be far more rapid and more effective than protests to a distant bureaucracy which had no roots in the governed communities.

B. Community development equated with alternative health?

Health is one of the key elements of life, most of all in the years of child-bearing and child-rearing. Much of the trauma faced by families is linked to health failure, itself linked to nutritional, environmental, social and other causes. It is significant that many community-based early childhood programs now have health as one of their core concerns. However such concerns are often rather limited, such as encouraging parents to make better use of the available community health services, including immunisation and screening. Beyond that is an area of vast potential in which people could be encouraged to take more control over their own health. They would be encouraged to:

- recognize the key part played by nutrition rather than hygiene
- learn that there are many simple old-time remedies which are as effective or more so than the powerful medicines dispensed at surgeries for minor ailments, and most of all
- become sufficiently attuned to their children's and their own health to know when to go for the best medical help and when to rely on more basic proven or 'alternative' remedies.

It is too early to urge the greater use of herbal remedies, of vitamin and mineral supplements, of astonishingly effective practices such as acupressure, reflexology, baby massage and other modern alternatives. As always, it is the educated middle classes who are already well into these alternatives, while the dispossessed are still totally dependent on expensive medical care. Alternatively, because of a lack of money they put themselves in the hands of local charlatans who sell out-of-date antibiotics and other dangerous remedies. The significance of this issue is that over thousands of years there has been a continuing struggle between the narrow so-called 'scientific' approach to dealing with illness, and the vast range of alternative approaches, many of which are holistic and geared towards the maintenance of health in its widest sense. The former is rooted in an elite, the latter rooted in the community.

The most potent example of this struggle is that of midwives who in some modern states today are banned or seen as a danger to birthing women. Yet the research evidence has shown, controlling for every risk factor, that midwifery care is safer than medical care at

birth. A more distant example is the murder of great numbers of women in Europe in the middle ages, alleged to be witches because they practised herbal remedies, offered counselling and practised what was in fact a form of alternative medicine. This is not to deny that there are life-saving elements in the scientific medical approach which no other approach can equal, but those elements do not justify the rejection of the many other approaches which can often preserve health at a lower cost in money and bodily integrity. It is still a far cry to see the development of alternative health strategies as linked to community development, in view of many people's unwillingness to recognize alternatives as an actual widening of choice beyond the rather narrow range of medically based solutions to their health problems. But there is evidence of progress towards an integration of mainstream and alternative approaches, especially when far-seeing doctors link their own medical expertise to that of alternative practices, using each when appropriate, and willingly sharing knowledge and strategies with those they treat.

C. Women's right to choose

It is inevitable that the development of community-based early childhood programs will expand women's right to choose across a range of options. This is not only for the practical reason that women involved in such programs come to recognize their talents and potential, and often find the confidence to take up employment opportunities, but also because the more that community programs develop the more conscious they become of the need to expand the range of possibilities for women. The development of local community-initiated child-care groups is a prime example, freeing mothers of pre-school children for some part of the day. A more distant goal would be the encouragement of greater choice at the time of birth, and greater involvement in decisions about their children's health care, based on greater knowledge. Increasing pressure should be put on State treasuries to fund family child care as of right, rather than funding employment-based child care as an aid to the economy. Women's choices about child care should not be dictated by economic necessity, but rather by their own decisions in the light of their own needs, with all mothers of young children being paid for child care, whoever undertakes it.

D. The missing human factor

We have moved far from the heady days when the media highlighted the numerous examples of successful single mothers as evidence of the liberated world of tomorrow. The men were relegated to a shadowy world in which they were portrayed in several famous films as generally incompetent, feckless or even evil. The injustice of generations of discrimination against women was replaced, in the public perception, by the marginalisation of men. Claims for the reintegration of the father into the family were regarded as an affront to the skills of women.

Today there is a sombre awareness that the increasing breakdown of society, the soaring levels of young male crime, and the alienation within communities has a great deal - though not everything - to do with the absence of the father figure from the family. An increasing volume of research is pointing in the same direction. However successful a minority of women have been in rearing their children in the face of daunting odds as single parents, a great many more women in single parent situations have to bear not only greater poverty and stress, but also an inability to cope with their children. They have problems especially with their male children, in a situation where there are no male

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models to set an example and help in the child-rearing. This is a general societal problem. One could speculate that the more communities become empowered by early childhood and other developmental programs, the more they will assert themselves to demand from the minority of defaulting men some greater awareness of their responsibilities. Perhaps it could be as a condition for being allowed to remain part of their community. State tax allowances and social policies may help, but can only play a subordinate part in the wider pressure to reintegrate the father in the family. The father cannot be forced to return to a family situation where he is not wanted. He could however, be encouraged to develop those parenting behaviours which will make him a desirable and essential part of the family. Again it is communities themselves which can help to achieve this, more so than the wider society whose values are often rejected by the communities most in need.

Early childhood programs - ranging from child-focused to parent-focused

There is a wide range of early childhood development programs which offer varying levels of parent and/or community involvement. Those with the least involvement tend to be the least empowering of either parents or communities. They are the most focused on ordinary pre-school child care in institutional settings. They often have outside professionals in the senior positions with the local mothers occupying the junior positions.

The next group includes an interesting range of programs which combine parent support initiatives, especially group work, and child care facilities as part of the same provision. Thus parents are helped with child care but also offered the chance to meet with other parents. In some cases these programs have strong parent and community involvement in the management of the programs, and, occasionally, even in the design of those programs. In other cases they are strongly institutional in their control, with charitable or state organisations running the programs and largely deciding on their structures.

The third group includes programs which focus mainly on parent support, either in parent group settings or on an individual basis such as in the community mother programs which our Centre has helped to set up and develop in Ireland, the UK and Australia. Some of these programs, even those geared to supporting parents on a one-to-one basis, are hierarchical and dominated by professional ideas on how parents should be 'trained' or taught. Fortunately there are many others, including the community mother programs, which make use of experienced mothers from the local communities to visit other mothers and offer empowering support and encouragement.

In each of these three groups there are programs varying in philosophy from strongly didactic and dependency creating, to those which are deliberately empowering. It has to be recognized that the didactic, professionally controlled programs tend to be run more efficiently and claim to achieve more short-term success as measured by formal changes of behaviour. In contrast, the more empowering programs tend to be slower to achieve, but also bring about more fundamental long-term, motivated change in the parents and lead ultimately to more empowered communities.

Conclusion

Across the world there are many new initiatives in community-based early childhood development programs. These include numerous forms of home-based day care and parent support in the home individually or in groups. There is also parent support in institutional settings, programs enhancing the role of fathers, developing the skills of

teenage parents, operating parent-run crèches, working with migrant families isolated within a different culture, or using 'resource families' to support other families. There is the development of family support alliances, the empowering of families in emerging societies to enable them to adapt traditional child socialisation methods to radically new circumstances, and much else. All these programs recognize the need to foster the skills of parents in societies which are making ever more demands on how children should be reared and developed.

Many State and local governments tend to believe that it is their role to impose a uniform and often hierarchical and narrowly focused model of parenting, to make up for the diminishing role of the extended family. The community-based initiatives offer a more holistic and varied range of approaches to parent support and early childhood development. The present situation for community-based initiatives is relatively favourable, despite the shortage of funds, as governments welcome any programs which may help to stem the rising level of family breakdown and violent youth crime. But these favourable days may not last. It is in the nature of bureaucracies to want to control whatever developments may influence the nature of their societies, rather than trust to the wisdom and experience of local communities. What we see today as an exciting panorama of innovative community-based programs can in the years to come become ever more state controlled, with state support favouring the more conformist and authoritarian programs, while the more radical will be left to wither. History tells us that state control has already been established in many other areas of life, including health, schooling, housing and much else. It also tells us that what takes the place of the community initiatives will be less innovative and far more costly, creating jobs for outsiders rather than for the local communities.

State control is likely to be imposed in the name of cost control and quality control, and any serious problems in some community initiatives will be held up as an example of why the State has to take over all of them. The State's demands for control will be fuelled by An awareness that community-based initiatives are of their very nature alternative power bases, with their own political and social implications. The fact that these initiatives will require State funding to continue and expand gives the State an additional hold over them. Thus the urgency for everyone else involved in early childhood programs is to develop and strengthen their community roots, to build up community structures and find ways of making them dynamic and sustainable. In the decades to come they would then be strong enough to demand that the State's role should be limited to financial support and the regular monitoring of quality and effectiveness, with the programs always remaining in the hands of the communities themselves. Much work needs to be done to explore these possibilities, if this movement is to survive and grow. It should be the universal right of all parents to receive empowering support from their own communities for the challenging task of rearing young children.

PART II: THE PROGRAMS

6. RURAL FAMILIES, RURAL STRENGTH AND HOPE

Barbara Clinton and Judy Matthews-Taylor

Poverty in the rural areas of the United States impacts the health and well-being of families, particularly children, in alarming ways. However, there are many strengths inherent in rural communities as well, primarily the heart and spirit of local people. The Maternal and Infant Health Outreach Worker (MIHOW) Program draws on this strength to enhance the lives of disadvantaged children. MIHOW's network of programs, located in the southern USA, are community-based and community-run, although they are supported in a variety of ways by a major university. Local agencies or clinics decide the specific methods and direction for their own programs within the MIHOW framework. Building on a history of organizing and self-help in these communities, paraprofessional outreach workers provide peer support, links to existing health and social services, and pre- and perinatal health information to rural families. In addition to the families, the outreach workers become empowered to grow and improve their own lives. In these ways, the entire community grows as a result of MIHOW. A number of studies attest to MIHOW's success, as do the words of outreach workers and mothers who have been participants.

The Maternal Infant Health Outreach Worker Project

In the very wealthy United States, the poverty rate among children is twice that of any other industrialized nation (1993 report from the United Nations Children's Fund). Low-income children suffer from health problems all through their early years. They lose forty percent more school days because of acute illness than other children do, and they are twenty times more likely than non-poor children to be unable to attend school due to chronic conditions. Rural children are among the most disadvantaged. They live in the poorest regions, and those most neglected by mainstream America. Unemployment is high, and medical and social services are inadequate or inaccessible. Yet despite severe financial hardships and lack of services, many rural people - parents, children, and workers - remain optimistic about the future. These people are the heart of the MIHOW project.

MIHOW is a community-based intervention aimed at improving health and child development in the Appalachian Mountains and the Mississippi Delta regions of the United States. Sponsored by Vanderbilt University in Tennessee, each MIHOW project is also sponsored by a local agency. There are 17 such MIHOW sites at present, located in Tennessee, Kentucky, Virginia, West Virginia, and Arkansas. These community-based organizations work in partnership with each other and with the Center for Health Services at Vanderbilt University, which provides technical training and support.

Local mothers who are known and trusted in their communities are recruited by the local sponsoring agency, are trained by the program, and become paid paraprofessional home visitors. They visit low-income, high-risk pregnant women and families with young children in their homes, before and after childbirth, providing health and child development education, support for healthy lifestyles and positive parenting practices, and help in gaining access to health and social services. Parenting groups give parents an opportunity to share experiences and learn from each other.
MIHOW begins with the goal of improved infant and maternal health, but it does not end there. The empowerment of individuals, families, and communities can lead to long-term, sustainable responses to serious inadequacies in social services.

Methods

Through home visits and group meetings, the program's principal method is peer-to-peer support. Because the home visitors are from the communities they serve - they are, in fact, peers to MIHOW mothers - they are able to establish a bond of trust among people who sometimes are fearful of outsiders.

> One MIHOW mother commented:
> *I really looked forward to my home visits. My home visitor taught me a lot of good things that helped me to understand what I was going through. It was a special relationship because I knew I needed to talk to someone and it had to be someone I could trust. I trusted her and she understood my situation.*

This level of trust has far-reaching impact. The relationship between the home visitor and the mother often improves the mother's perception of her strengths and her ability to look at new options.
One mother in Appalachia, for example, gave birth to a baby with a cleft palette. When the baby was a few months old, the home visitor, who was beside her when she gave birth, gently suggested that surgery should be performed to correct her daughter's condition while she was young. The mother was too frightened of doctors and hospitals to do this. The home visitor didn't push her, but instead left literature for the mother to read after home visits. After several months, the mother decided to have the surgery done, and asked the home visitor to stay with her during the procedure, which was a success. Not long afterward, another mother in the community gave birth to a baby with a cleft palette. The first mother readily agreed to talk with her about her own experience and was able to support her in choosing corrective surgery for her baby.

Primary stakeholders

As the MIHOW name makes clear, the outreach service is targeted for mothers and babies. Those impacted by MIHOW, however, form a much wider circle. The four primary beneficiaries are:

1 Children

Through intervention that begins prenatally, babies are born stronger and healthier. Children are more likely to be breast-fed and to receive immunizations against childhood diseases. They receive a fair start in life. When parents have support and good advice on developmental milestones, nutrition, and behaviour management, children have a more joyful and healthy early life.

2 Family members

Through the project, mothers first acquire new knowledge about health - both their own and that of their children - and about child development. As they learn and gain new skills, they acquire self-confidence and obtain the services their families need. The rural mothers with whom MIHOW works generally mobilize extra energy and improved parenting skills, when encouraged by a sympathetic, well-trained peer. After receiving home visits for one to two years, mothers are encouraged to join parent groups, thus continuing the support and learning they have experienced in working with the home visitor. The groups help to break the isolation felt by mothers in rural areas. The women often learn, that they have something to offer to others. Participation in groups can lead to wider community involvement. Fathers, grandmothers, and other family members also gain a richer understanding of parenting.

This year, the program launched a series of outreach strategies aimed at fathers, recognizing their crucial role in children's development. After conducting several brief surveys of fathers, we offered small grants to local program sites to develop and implement short-term projects to learn more about how best to encourage fathers' engagement in their children's lives. As a result, summer activities at our sites included group outings for fathers and children, camping, a Father's Day essay contest and softball game, and a gun safety class.

3 Home visitors

MIHOW home visitors also benefit directly. Regularly scheduled trainings and workshops build confidence and competence. The home visitors learn from the mother and families they contact. It is important to understand that the home visitors are not simply an extension of the professional establishment. Rather, as members of the same community as the MIHOW families they work with, the home visitors are peers who serve as models for younger mothers. They also serve as a link between the families and the medical and social services communities, as well as the community at large.

4 Communities

Each local project leader is a community resident and mother with training or experience in education, social work, or community development. Project leaders recruit and train other local women who are active mothers, care deeply for their children, and have learned about health and parenting from their experience in the family. They are members of the natural helping network of women who help each other learn about pregnancy, birth, and child development. Our project identifies these women, provides them with training and supervision, and then lets them continue their work of helping other women be good and healthy mothers. Staff from the local communities are involved in every aspect of the program, from developing the training to designing and implementing evaluations.

Evaluations of the program show that the MIHOW approach enables community organizations to respond to a wide range of community needs. Due to the project's investment in local leaders and organizational development, local communities have used the MIHOW project as a base for new expanded efforts that support low-income families. Each of the MIHOW sites has attracted state, federal, or private funding to expand their outreach and advocacy efforts. Having the MIHOW program in a community has led to

the development of new local programs, an expanded training capacity in the community, more responsive public institutions, improved co-ordination of community services, and additional community attention to children's health and family needs.

Theoretical basis

The strategy of organizing women to reach out to other women builds on the strengths of rural communities and their self-help traditions. Many of our communities have a history of organizing for civil rights. Struggles against racism continue today. In the white Appalachian communities, there is a legacy of struggling for fair wages and safe working conditions, especially in coal mines, railroad yards, and textile mills. Helping the communities' children by organizing and strengthening community institutions is a logical approach, given this local organizing heritage.

Like the women they visit, MIHOW workers are survivors of severe economic hardship and depression. As a result, workers and mothers tend to respect each others' efforts to cope. This helps home visitors work with participants in a non-judgmental way.

Program impact

Evaluations of the program reveal impact in several areas of concern to MIHOW's stakeholders.

1 Health

In a study of the MIHOW project sponsored by the Ford Foundation (Clinton, 1992), findings showed that MIHOW participants, compared to controls:

- consumed more vitamins and iron, and less tobacco and caffeine, during pregnancy;
- received more prenatal medical visits; and
- were more likely to breast-feed (33.3%, compared to 22.5%).

In a qualitative study (Clinton, 1990) sponsored by the Bernard van Leer Foundation, almost all of the participants said they had learned more about health as a result of their participation.

2 Child Development

Participation in MIHOW has been shown to positively affect the development of children whose mothers are enrolled in the program. In focus groups and interviews several mothers noted their children's gains in verbal, reading, and social skills while participating in MIHOW (Clinton, 1990). Other studies have pointed toward such effectiveness as well.

- The Caldwell HOME Inventory was given to MIHOW and comparison mothers when the child was approximately a year old and again at around two years of age. The HOME assesses mother-infant interaction and parental management of the infant's environment and has been positively correlated with later IQ scores and school performance. MIHOW mothers scored significantly higher than mothers in the comparison group at both one and two-year interviews (Clinton, 1992).
- A shortened version of the Denver Developmental Screening Test, containing 16 items from the Personal-Social, Gross Mother, and Language Scales, was administered to children at age two. Children whose mothers were in MIHOW scored significantly higher than controls on the total score and on all three subscales. MIHOW mothers interviewed for the study reported that their participation in parent groups had helped them interact more positively with their children (Clinton, 1992). Children of MIHOW participants, in a quasi-experimental study, scored higher than controls on the

academic and self-help subscales of the Developmental Profile II at one year (Clinton, Skaggs & Maloney, 1996).

3 Mothers' achievement

Mothers who have participated in MIHOW learn and grow in a variety of ways, both within the family and beyond. One MIHOW mother told the interviewer in a qualitative study: "*I learned how to take care of my baby, what to feed him and the things to do, such as reading to him, singing to him, and having a time for just him and me to be alone*". Another said,"*I am getting things slowly but surely accomplished. I am learning better parenting skills and doing well in GED; I am ready to take my tests*". Participants in the study also said their sense of purpose and hope for the future had improved as a result of their participation in MIHOW. Many also gave examples of improved decision-making on family planning that they attributed to the program's influence (Clinton, 1990).

Home visitor Debbie Withrow of New River Health Association talked about a MIHOW mother she has worked with and is especially proud of, a woman who had been considered mentally disabled. "*Now she's gotten her driver's license, works, deals with her son's teachers, and has been a support person for other family members who have had babies and are also very limited*" (Withrow 1996).

The MIHOW program's hypothesis is that the home visitors, because they are peers, act as powerful mentors to MIHOW mothers. Mothers see the learning, self-assurance, and achievement of women like themselves, and a seed is planted. As Mercy Mission's Pat Haynes expressed it, "*I meet moms that are down and out like I was in the past, with nobody to talk to, and who do not know how to take care of their babies*". She tells them, "*I am here to comfort you when you just need somebody to talk to. I have been kicked. I have been beaten. I have been through the welfare system just like you have, but I came out of that, and you can, too*". (Haynes 1996)

4 Mother's empowerment

In a Virginia-West Virginia study, the percentage of MIHOW participants who said they knew how to help themselves or someone they know get community resources was significantly higher than non-participants for these five services:

- affordable medical care (81% to 62%)
- transportation to medical care (84% to 62%)
- well-baby medical services (98% to 72%)
- assistance with alcoholism, drug abuse, or depression (72% to 46%)
- support groups (42% to 22%)

(Maloney, 1995).

As the child becomes old enough for the home visitor to discontinue regular visits (usually at around 24 months), MIHOW participants are encouraged to join or to form parent support groups. Compared with non-participants, MIHOW mothers receive significantly more help from friends, parent groups, and social groups (Maloney, 1995).

The community development and advocacy tone of the MIHOW program encourages activism on behalf of pregnant women, infants, and families with young children. In Kentucky, Tennessee, and West Virginia MIHOW mothers were more likely to obtain public insurance to pay for their deliveries (Clinton 1992), confirming earlier data which

showed that involvement with MIHOW had helped reduce participants' sense of isolation and increased their assertiveness with welfare and legal systems (Clinton 1990).

5 *Enhanced citizenship*

Many participants and former participants serve on committees, advisory boards, or boards of directors of the local MIHOW sponsoring agencies. They have been partners with site staff and others in starting and developing such community programs as parenting education, child care centers, family planning, child abuse prevention and job training, verifying the earlier findings that determined that MIHOW had a powerful and positive impact on the participating families, on the women providing the services, on the leaders managing local programs, and on the local organizations sponsoring the intervention.

Successful program strategies

The MIHOW model incorporates several key methods that have helped it become a successful outreach effort. An emphasis on local staff/local program ownership, startup and ongoing university-based support, and a strong network among sites bolster the program's ability to reach rural families needing health information and services. In more detail, these strategies include:

1 Locally administered baseline surveys

In each community site, we begin by hiring local mothers to interview their peers. A simple survey instrument has been devised which seeks information on the family's economic level, the number of children and their ages, and basic health information about the family. By providing a small amount of financial reimbursement to women to collect the data, we introduce the program as one that is concerned about children, but respects the value of mothers' time as well.

While we began this process to develop baseline information, we have learned that this is a key strategy for engaging local women in the project. In nearly every community, we have seen the surveyors become more concerned about the state of children in their own communities. Although the surveyors do not always become home visitors, they are important in identifying potential home visitors, as well as families who might receive program services.

2 Providing initial program money to local sites

In a similar way, by providing a budget to the community organization which sponsors the local program, we assure that the MIHOW program has a certain amount of stature within the sponsoring organization. Coupled with the seed money, we provide several years of training in family support services, program planning, proposal writing, and general fundraising. This strategy allows sponsoring organizations to develop additional expertise in providing services to families, in order to gradually wean themselves from the Center for Health Services. After three to six years, the local organization can become financially independent of the Center. While this has not happened in every case, in nearly all of the local communities where the program has been in existence for at least three years, a significant amount of local support has been raised. A number of our original programs are now fully independent, with budgets exceeding $100,000 per year.

3 Rural programs as part of a network

Because our work is exclusively in isolated communities, the existence of the MIHOW network has been important for assuring quality in training and evaluation, for supporting morale at difficult times, and as a way to allow established programs to serve as models for newer programs. Local program staff and mothers have come to recognize that problems in their communities are not particular to them, but are problems that they share with other areas dealing with the same economic conditions. Training sessions always include time for mutual problem solving. In these ways, local programs learn from other local programs. The assistance they receive from their peers is different, and often more helpful, than we can provide from a university setting.

4 The university base

The university base for the MIHOW program offers unique advantages. We draw upon the assistance of students and faculty in providing training and program evaluation as the program grows and evolves. Through the university libraries, we are able to access the most recent health related research. In addition, members of the university community become more aware of the achievements of low income communities in our own country.

5 Site co-ordinators

Because our program sites are spread across an area of approximately 800 miles in five states, it is physically impossible for a representative of Vanderbilt University to visit them all on a regular basis. By utilizing a skilled 'site co-ordinator' in the eastern region and another in the western region, we provide a human connection back to the Center, and monitor challenges and achievements during the local program's development.

6 Central training sessions

In these two- to three-day residential meetings, representatives from each site convene in a relaxed setting for training in health, child development, and related areas. Time is also devoted to music, crafts, and community-building activities. We have worked carefully to develop a good balance between relaxation and what might be considered 'hard work'. We have found that the less structured time with each other helps build a sense of identity within the MIHOW network and a sense of mutual reliance among local programs.

7 Home visiting as an intervention strategy

Home visiting is non-threatening for the home visitor, as well as the woman being visited. It is informal in nature, although the home visitor follows a well-designed curriculum. The setting is the "turf" of the woman being visited. In a subtle way, this switches the power relationship towards the mother, in contrast to a classroom setting, which is considered to be the "turf" of the teacher. The home visitor also becomes a powerful role model for the mother, encouraging her by example to grow as a parent and as an active participant in her community.

Strengths and weaknesses of MIHOW

One of MIHOW's strengths is the overall project design of building communities by training local mothers to work with pregnant women and families with young children. There are associated challenges, which include identifying qualified local women, developing effective helping relationships with multiple-problem families, and gaining the respect of health care providers for our home visitors as team members.

Another strength of the project is its community ownership. Each MIHOW program is sponsored and run by a local agency with an advisory board or board of directors composed of community members. This allows the local community to tailor its program over time, reflecting local needs and resources. Especially in Appalachia, there is an associated challenge due to cultural reservations about relying on anyone outside the family for assistance. In addition, many participants lack self-confidence and experience in interacting effectively with those they perceive to be 'in authority'.
Communities find it difficult to secure funds to start new programs and to assure long-term sustainability. We strengthen our local community programs by working with them to develop year-long sustainability plans. A Development Co-ordinator travels to each site and meets with agency directors and other key members of each local organization to guide them through development of their plans, and follows up throughout the year on their progress.

Although rural children are among the most disadvantaged in the United States, the MIHOW program demonstrates, in community after community, that committed parents can significantly enhance children's lives with only modest technical and financial assistance.

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7. PARENTING PROGRAMS IN SOUTH WALES

Maria Gallagher, Joy Mason, Jill Rossiter and Miskey Sandison

'There should be a parade when a baby is born'.
(From: Open House for Butterflies By Ruth Krauss, 1960)

Introduction

In this chapter, we describe three community parenting programs in the United Kingdom, each of which started independently but developed along similar lines. At the end of the chapter, we draw some common conclusions from their independent development. What they have in common is that they use a training program with volunteer nonprofessional parents in order to encourage the skills and self-confidence of first time parents.

Background

Research findings from the Dublin Community Mothers Programme, in the Republic of Ireland (Johnson and Molloy, 1995), confirmed that this style of program resulted in an increase in self-esteem and confidence, both of those delivering and those receiving the parenting support. Positive attitudes to parenting were established which in turn resulted in the additional benefits of improved health status.

In March 1995, the Valleys Health Group, a development agency of the United Kingdom's Welsh Office, became interested in community parenting schemes. The remit of the Valleys Health Group was to encourage innovative health promotion programs in the old coal mining areas of South Wales. They had become aware of the Community Mothers Programme in Dublin, and had contacted Brenda Malloy for information and assistance. She made several trips to Wales to talk to health visitors and administrators about the program in Ireland and two groups from Wales visited her program in Dublin. Bert Prinsen sent materials from the Moeders Informeren Moeders program, in the Netherlands and Mother Net America gave excellent access to program materials in the United States.

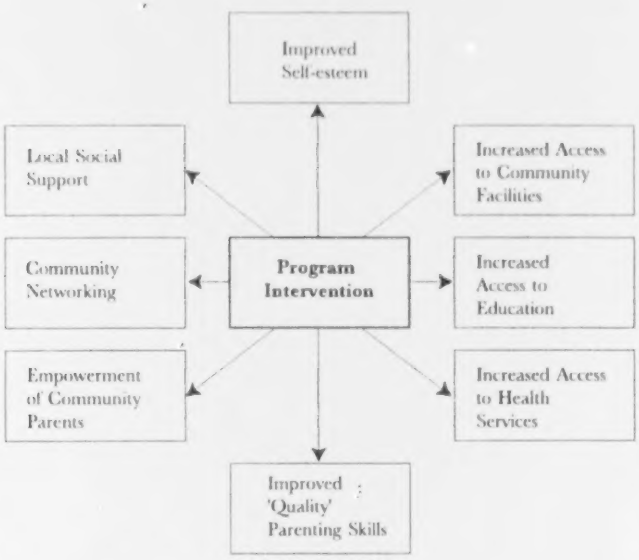
The Welsh Office then funded two parenting programs from the Welsh Office Innovation Zone Monies. These were:

- Torfaen Community Parents Program
- *'Right From the Start'* Parenting Program - Rhymney Valley

A third project, *'The Den'*, run on Duffryn, an estate in Newport, was funded by the Gwent Health Authority as a community public health initiative. These three areas of South Wales had been identified by the three local councils as being socially deprived. Health visitors were concerned that parents in these areas lacked confidence and self-

esteem both in themselves as individuals and in their parenting ability. Moreover, families here lacked family support networks and consequently had no model of parenting to follow. Frequently the birth of their first child was their first experience of caring for a baby.

Shared goals of the three parenting programs



Each program has developed the processes to achieve these goals differently. We will describe these differences later in this chapter. The following chart demonstrates some of these differences in the management of each project:

TORFAEN	RHYMNEY VALLEY	DUFFRYN
Office based in a local hospital.	Office based in a local hospital.	Office based in the community.
Health visitor led.	Health visitor led.	Midwife led.
Co-ordinator is a health visitor.	Co-ordinator is a health visitor.	Co-ordinator is a community development officer.

Table 1. Management of three programs

Why now?

There were many reasons for starting the programs at this time:

- The nursing profession had identified the need to mobilise resources (i.e. Primary Health Care Nursing Team members and members of the public) to maximise the positive impact of health intervention.
- There had been a shift from centralised services to health care being delivered locally.

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- Policies had evolved to encourage the public to take more responsibility for their own care.
- Government had recognized the necessity of improving parenting skills.

The training package

In March 1995, the Valleys Health Group and others involved in the 'Right from the Start' program began to look at existing training materials which were being used for community parenting schemes in the United Kingdom, the Netherlands and the United States.

After looking at other volunteer parenting programs and their materials, it was decided in South Wales to develop the training package locally. Although there were many interesting ideas and some novel ways of presenting materials, nothing really met the specific needs of the Community Parents Program we hoped to develop for South Wales, particularly those of the Valley communities. These needs would only fully emerge as the program unfolded and all those involved, including the community parents, had made contributions. Another consideration in deciding to develop our own materials was the prohibitive cost of some of the more established programs.

Two important concepts influenced the development of these materials: a strong belief in Piaget (Phillips, 1969) and Erikson (Erikson, 1951) based child development theories and the feeling that '*good enough parenting*' is best carried out by parents who have good personal support from family, friends and professionals with helping skills. The training materials are organized in a flexible loose leaf format so that they can be easily edited as the need arises. For instance, the information about preventing cot death changed twice during the writing of the materials. The format was kept as simple as possible with many open-ended questions, illustrations and cartoons. The major goal was to offer support rather than advice. The handouts have been carefully edited by a literacy expert. When the program becomes more established, it is hoped that the mums who are visited will also suggest changes so that the materials will better meet their needs and reflect their interests.

It is clear that the success of these kinds of programs will very much rest on the selection, training and continued support of the volunteer parents (see table 2). Looking for appropriate personal qualities in the volunteers and helping to develop good communication skills, through the training program, will help ensure a good outcome. The training program for the volunteer parents has been developed to help them to utilise their own skills, to learn about some of the new thinking in

COMMUNITY PARENTS SELECTION CRITERIA

ESSENTIAL QUALITIES:

Will have a proven experience of positive parenting

Will live in the community they will be supporting

Will be in good health and have enough time to devote to the project

Will be able to demonstrate literacy

Will be able to communicate effectively

DESIRABLE QUALITIES

Will have an interest in providing a caring service

Will understand and respect the need for confidentiality

Will have a knowledge of their community

Will have a warm, encouraging personality

Will be non judgemental

Will have a belief in the need for parents to solve their own problems

Will be able to accept responsibility and carry a task to completion

Will have good listening and responding skills

Will be able to demonstrate problem solving skills and be able to access resources and information for first time parents

Will be able to liaise with different agencies

Table 2. Selection criteria

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baby and parent care and to practise good communication skills, such as reflective listening and the use of open questions. The initial training is a six-week program but the training continues with the co-ordinators ongoing support of the volunteer parents as they make their visits to new parents and their babies. The provision of ongoing and encouraging support for the volunteer parents, the co-ordinator and the rest of the program team is absolutely essential for the long term success of this program (table 3).

What are we hoping will happen?

When you give your support to parents we hope they will understand:

- that they are OK parents who often know what is best for their baby
- that breastfeeding can be good for them as well as their baby
- that there is support for the many mums and sometimes the dads who feel sad after the birth of a baby
- that attending baby clinics can help their baby to be well and happy
- that babies can surprise us all and have accidents that we might be able to stop
- that good food can help a parent feel stronger and able to cope(as well as help make milk for breastfeeding mums)
- that babies love to learn about their world from their parents

Table 3. Supporting parents

Objectives to be delivered by the Community Parent

1 Encourage baby/parent interaction so that baby and parent will stimulate each other:
   - Talk about and notice the baby's most recent developmental skills with the parent.
   - Introduce new ideas such as baby reflex skills and new materials such as songs, books, and toys.

2 Model parenting behaviours that are normal and desirable:
   - Talking to baby while doing activities.
   - Encouraging Dad to participate during a visit (table 4).

3 Support parents in coping with the transition to parenthood:
   - Listening attentively to parents talk.
   - Observing body language and environmental influences.
   - Responding with empathy using reflective listening skills and open questions.

4 Offer some information about baby and parent development:
   - Show leaflets and cartoons that highlight baby's and parent's physical, emotional, social and medical development.
   - Pass on information about other agencies which can offer assistance

Father

It's important work being a father.

Your baby will love you getting to know each other. You are a very special person. From you, a baby learns the difference between a man and a woman. A baby's loving relationship with a father helps the baby learn to be more accepting of other new people and situations.

Babies are interested in their fathers because.....

- Your body can often be bigger and feel different.
- You can smell different.
- You can have a deeper voice and facial hair.
- You can play different games from mum.

Your baby needs:

- Your smiles.
- Close, loving cuddles.
- Talking to.
- Playing with.
- A song.
- A feed(mum can give you a bottle of breastmilk).
- A nappy change.
- A bath.
- An outing with dad.
- A walk about on the "crying" days and nights.
- An older baby will like a story from a baby book.

Table 4. Being a father

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in the form of leaflets, telephone numbers and personal contacts, such as parent support groups.

5 Assist parents in the development of problem solving strategies and conflict resolution:
- Using observation and creative brainstorming techniques.
- Encouraging open communication skills.
- Helping a parent develop a plan.

Summary

Using the program materials helps to create a structure that assists the achievement of desired health gains and the support and encouragement of parents. They can also be part of the ongoing evaluation of the program. The information on the loose leaf handouts can be easily changed, allowing for innovation and flexibility on the part of the co-ordinator and the volunteer mums. Everyone involved with the program, from the managers to the first time parents, is encouraged to suggest changes so that they can feel comfortable with as well as having ownership of their own program materials. As a result these materials can better accommodate the needs of these communities while reflecting the rich diversity within them (see table 5).

'Right From The Start' - The Rhymney Valley Program

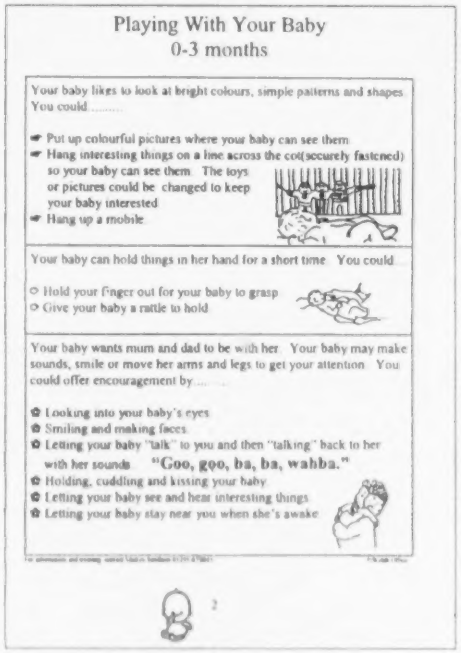
The '*Right From The Start*' Parenting Program is based in the Rhymney Valley area of Caerphilly, South Wales, the initial pilot site being in an area encompassing the communities of Cefn Hengoed, Ystrad Mynach and Bargoed. The program was funded by the Welsh Office Innovation Zone Monies for one year, with the aim of the Welsh Office to 'kick start' worthy projects. The program has since received funding from the local authority, which enables the project to continue for another year.

The project team consists of:
- Project Manager
- Co-ordinator
- Multi-agency Steering Group
- Health Visitors
- Midwives
- Volunteer Community Parents
- Parents with their first babies
- The Secretary

The program is managed within the local Health Services.

How the project began

In 1993, Janet Carr, head teacher at Derwendeg primary school in the Rhymney Valley, called together local professionals from Health and Social Services, the local authority and voluntary agencies, to discuss developing an initiative to help parents develop their parenting skills.


Playing With Your Baby
0-3 months

Your baby likes to look at bright colours, simple patterns and shapes. You could.....

- Put up colourful pictures where your baby can see them.
- Hang interesting things on a line across the cot(securely fastened) so your baby can see them. The toys or pictures could be changed to keep your baby interested.
- Hang up a mobile.

Your baby can hold things in her hand for a short time. You could.....

- Hold your finger out for your baby to grasp.
- Give your baby a rattle to hold.

Your baby wants mum and dad to be with her. Your baby may make sounds, smile or move her arms and legs to get your attention. You could offer encouragement by.....

- Looking into your baby's eyes.
- Smiling and making faces.
- Letting your baby "talk" to you and then "talking" back to her with her sounds. **"Goo, goo, ba, ba, wahba."**
- Holding, cuddling and kissing your baby.
- Letting your baby see and hear interesting things.
- Letting your baby stay near you when she's awake.

2

Table 5. Program material

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Janet said in a newspaper interview: "*I know the struggles of many families, emotionally and financially. A lot of money is spent trying to put problems right, but we are acting before they develop, empowering mothers and improving parenting skills. In a decade we will see a measurable difference.*"

The initiative was supported by local midwives, health visitors and the local general practitioner medical practice. A project co-ordinator was appointed in October 1995, who worked to recruit, help train and support the volunteers. Baseline criteria for evaluation were laid down at that time but it became increasingly difficult to plan for the future as the year progressed and the prospects of further funding faded.

The co-ordinator had to finish in October 1996, but the professionals and volunteers were so committed to the project that it managed to continue for six months without a co-ordinator. Administration suffered and developments in the project came to a near standstill. However, a health visitor has now been seconded for a year to the project as a result of local authority funding, and the project is set to expand from the initial pilot site to be part of the core service provided to all mothers with new babies.

The program supports the role of the health visitor or midwife and the advice they give. The community parent backs up that advice, and is instrumental in encouraging the mother, for example, to attend a child health clinic to seek the help she needs.

One mother commented on the support given to her by the community parent: "*We chat about everything. She listens to all my moans and groans. I doubted myself before, but she backs me up. She tells me I'm doing a good job.*"

How the project works

The midwife discusses the project at the first visit to the ante natal clinic. The health visitor meets the expectant mother in the clinic and introduces her to the community parent volunteer. Unless requested, the community parent volunteers do not visit the mother until after the birth of the baby. The optimal time for visiting appears to be between 4 - 6 weeks after the birth of the baby. The community parent will visit the parent on a monthly basis until the baby is three years old. More frequent visits can be made, but this is negotiated between parent and volunteer.

The health visitors meet frequently to discuss how the project is going and to support the community parents, dealing with any concerns they may have. The project co-ordinator oversees and facilitates these meetings.

The Co-ordinator

1. Links public health policy with the community development approach.
2. Provides a community profile.
3. Offers training and support for the volunteers.
4. Co-ordinates publicity, marketing and networking.
5. Administers the program.
6. Undertakes research and evaluation.

The Volunteer

1 Provides a link between the professionals and the community.
2 Supports other parents within the community.
3 Takes part in the training program and participates in the visiting schedule.
4 Works within the program guidelines and code of practice.

Challenges

The project met a number of hurdles which the team had to overcome. These were:

- The size of the pilot site, which was initially too small, i.e., the birth rate was too low.
- Selling the project to families and professionals
- Communications - between professionals, the co-ordinator, community parents and the families involved
- Funding for the project
- Recruitment of volunteers.

Successes

The success of the project must be attributed to every team member - professional, voluntary and parents. Particular successes include:

- Parents accepting the program and finding the support of the community parents beneficial.
- Learning achieved by professionals, volunteers and families from the program materials.
- Grant from the local authority for one year to maintain the program.
- Establishing a community parent program in this area.
- A baby group co-ordinated by health visitors but run by volunteer parents.
- Networks with other projects.

"The Den" - Duffryn's Health Promotion Project

"The Den" is a community-based drop-in centre for teenagers and young parents, commissioned by the health planners for Newport and successfully tendered for by Glan Hafren NHS Trust. It is based on the Duffryn estate situated on the outskirts of Newport. The project was conceived in response to poor health indicators for Duffryn, such as low new born birth weight, low breastfeeding rate, poor clinic attendance, a high rate of educational special needs and low uptake of cytology(smear testing). The service aims include the following:

- To increase self-esteem and motivation to enable Duffryn residents to make better health choices.
- To improve the health status of Duffryn children.
- To increase the number of first time parents able to cope.
- To increase breastfeeding rates.
- To reduce smoking amongst teenagers and mothers.
- To reduce the number of teenage pregnancies.

The project is based in a three bedroom house in the centre of Duffryn. There are two full time workers, a project co-ordinator and a youth worker, plus several sessional crèche workers. The project has been open since April 1996 and houses a number of advice

services, space for training and a creche. The underlying philosophy of the project is that of empowerment, on an individual and collective basis. The area of Duffryn is characterised by poverty, high unemployment and a lack of community facilities with the subsequent lack of choices these factors can bring. Self-esteem amongst many of the young parents who live on the estate is low. A community base offering free facilities, useful advice services and an 'open door' policy seemed to be what was needed. The co-ordinator had a background in community development, not health, from her experience, the most successful kind of community facility was the kind that embraced the 'one stop shop' idea: a range of facilities and services which people could access easily within a single building.

During the last eight months "The Den" has become an integral and well-known feature of the estate, mainly because of the constant flow of publicity for any new activity and the relevance of services and activities. Already the user figures for the first year of the project are between 95 and 115 per week, the projected level for its third year. Many of these users are teenagers who access contraceptive and drug information, free condoms and pregnancy testing, whilst an older age group accesses these services and also training courses, the job board and careers advice.

During January 1997, we started the training sessions for Duffryn's community parents befriending scheme. All residents of the estate received leaflets through their doors asking them to consider becoming volunteers. From this large net of over 1000 houses, we recruited six volunteers, three of whom were already involved in activities at "The Den". By the end of the training we had a core of four volunteer parents. Their first visits started mid-April 1997. Support for volunteers is provided by the co-ordinator on a one to one basis within 48 hours of the visit. As Duffryn is a relatively small estate, it will be extremely important to maintain confidentiality within the scheme through close contact with the co-ordinator and regular meetings with other volunteers for useful exchange and feedback.

Table 6. Parental experience

Unlike other parenting schemes in Wales, Duffryn's scheme is managed by the midwifery department of the local health trust, through the co-ordinator of "The Den". It works closely with health visiting and other related services. Because of the strong community presence the centre already has in the area, we decided to try an 'opt-out' system in three stages:

- Parents are contacted 6-8 weeks after leaving hospital with information leaflets and a letter asking them to contact "The Den" if they do not want a visit.
- One week later they are contacted again and the opt out aspect is reiterated.

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- In the third week they are advised that a volunteer parent with an identification card will be calling within the next week unless they opt-out.

The Duffryn parent to parent program in operation, volunteer mum talking to a new mum photograph Clementine Sandison

The rationale behind the 'opt-out' system is that all parents will be offered support ensuring that those who need it most will not have to ask. Those who feel that they do not need it have the opportunity to decide for themselves that it is not needed. If they decide at a later date that they do want a volunteer parent to support them they can contact "The Den" to arrange this. At this stage, we have had three refusals from a total of 27 parents. Local midwives and health visitors will also carry a supply of information leaflets. This method of introducing the program to parents is still being reviewed and, because of concerns over issues such as consent and breach of confidentiality, it is possible that introductions to the program could, in the future, be initiated by the midwives, the health visitors, or the co-ordinator.

Monitoring of the scheme has been developed but it is envisaged that much of the data will be subjective and anecdotal. The study itself will be very small given the size of the catchment area. Any conclusions drawn from the research will have obvious limitations but it is hoped that, as a pilot study, the scheme will be very useful in determining how effective this kind of support can be. The monitoring of the befriending scheme is encompassed within the overall monitoring of the project.

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Torfaen Community Parents Program

The Community Mothers Program was initiated in October 1996 in the Torfaen Borough of South Wales, an area identified as deprived. The background of the program can be seen in the context of the new emphasis in health care away from secondary medical treatments and towards primary health promotion and the prevention of ill-health. Health, the UK Department of Health argues is about making healthy choices regarding life style, and can therefore be available to all (Health of the Nation 1990).

Implicit in this argument is the criticism of women's role as child rearers. They are considered to be responsible for the health of their children, and are blamed for choosing behaviour which inevitably damages their children's health: smoking, use of alcohol, stress, poor use of medical resources and inadequate diets. These elements combine to produce the phenomenon of poor parenting skills (Mayall, 1986). Emanating from this argument is the basic assumption that good parenting is an essential requisite for good health.

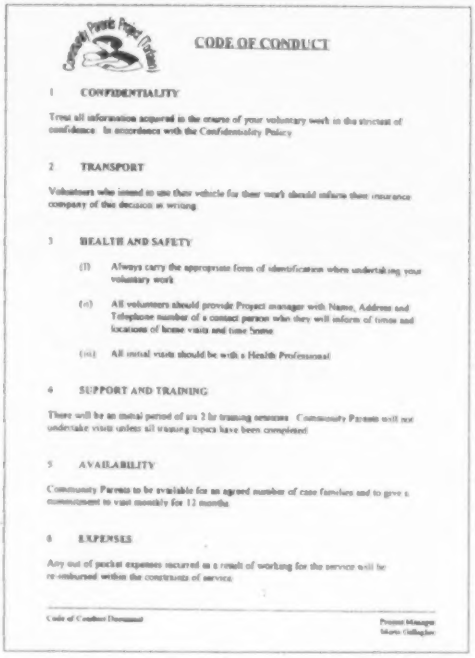
As a result of this thinking a number of research projects have concentrated on studying social interventions in motherhood, childhood and family life, including evaluating whether people are receiving the help they need to achieve the overall goal of health.

Project design

The direction of the Torfaen Project rested primarily on health professionals with a health visitor as the project co-ordinator. She was charged with establishing the project, selecting and recruiting volunteers, offering the project to all first-time mothers in the project area and monitoring and evaluating the parenting program offered. Unlike the other two projects, the Torfaen program was totally health led.

The health professionals steering the project carefully monitored each stage. As a consequence project development was slow initially but resulted in a project design which was methodical and well structured.

- *Volunteers were given their own contractual agreement. This included a 'code of practice', a confidentiality policy, a child protection protocol, and insurance cover. Police checks, references and an agreed training schedule were also undertaken before visiting commenced. Although it could be argued that the volunteers might feel threatened by such a bureaucratic approach, in reality it contributed to their feelings of worth and value since the Health Trust recognized them as part of the organization. Throughout the process the volunteers were welcomed as part of the team approach in the delivery of care.*



CODE OF CONDUCT

1 **CONFIDENTIALITY**

Treat all information acquired in the course of your voluntary work in the strictest of confidence. In accordance with the Confidentiality Policy.

2 **TRANSPORT**

Volunteers who intend to use their vehicle for their work should inform their insurance company of this decision in writing.

3 **HEALTH AND SAFETY**

(i) Always carry the appropriate form of identification when undertaking your voluntary work.

(ii) All volunteers should provide Project manager with Name, Address and Telephone number of a contact person who they will inform of times and locations of home visits and time home.

(iii) All initial visits should be with a Health Professional.

4 **SUPPORT AND TRAINING**

There will be an initial period of six 2 hr training sessions. Community Parents will not undertake visits unless all training topics have been completed.

5 **AVAILABILITY**

Community Parents to be available for an agreed number of case families and to give a commitment to visit monthly for 12 months.

6 **EXPENSES**

Any out of pocket expenses incurred as a result of working for the service will be re-imbursed within the constraints of service.

Code of Conduct Discussed

Project Manager
Maria Gallagher

Table 7. Code of conduct

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- *In order to avoid the criticism that it discriminated against those parents felt to be in need of additional parenting support, the project was offered to all first-time parents irrespective of need within the target area. All were offered the service by the general practitioner, midwife and health visitor. Acceptance was not forced but was actively encouraged, with the safeguard that parents could choose to leave the project at any stage.*

- *Following acceptance, and having completed their training, parents were matched with a volunteer. Introductions were made through the health visitor and home visits of approximately one hour were then arranged between the volunteer and the parents on a monthly basis for the first year of the baby's life.*

- *At each visit the remit of the community parent was to deliver emotionally sustaining support (Gottlieb, 1988). Each visit was structured by using specially designed information sheets which served to focus both the visitor and parent on achieving specific goals. In seeking to achieve these goals during the visit, the parent was always acknowledged as the expert in the care of his or her child.*

- *The role of the co-ordinator at this stage was to support the community parent and to facilitate peer support by organising group sessions for the volunteers to share ideas and to build on the skills and knowledge acquired. These group sessions, also open to professionals, were used to heighten enthusiasm for the project and to discuss any practical difficulties that arose.*

Discussion

Acceptance of the community parents by both professionals and clients was initially slow. However, a mutual understanding of how their roles fitted into current service provision has resulted in a more positive response to the respective project. First-time parents in Wales are traditionally offered a comprehensive home visiting child health service so it became necessary to define the role of the community parent within the existing set-up.

A need to establish a user group of health professionals and volunteers was identified. This group carefully researched the need for the project which was thought to arise from the parents' inability to ask their own questions and state their own needs when given professional advice. There was also an awareness that the professional advice given could sometimes be ignored if it was considered to be too complex or irrelevant, or if it was regarded as a criticism. Community parents, it was agreed, could help bridge this professional divide and enhance the acceptance and accessibility of parent craft teaching while also offering a social support network.

This has led to the following achievements:

- 20 first-time parents are now being visited and the project has been opened up to all parents with a new baby.
- 10 volunteers have been trained and 7 are actively visiting parents and training has commenced with a new group outside the original project's scope.
- Although not formally evaluated, the Torfaen Project is proving to be a valued service. Many of the volunteers are now on their seventh visit to their families. They report that the visits are now developing a structure and that they and the families can feel a real benefit and are "looking forward" to visits. The initial reservations regarding purpose and acceptance have now been overcome.
- The project which was originally developed by health professionals has now acquired a

Community focus. In order to improve its acceptability, the co-ordinator has actively encouraged its inclusion into the community strategy of the area. As a result, a grant has been received to look at developing its volunteer involvement.

- The project has facilitated the opening of a mother and baby support group (a baby club), which is enthusiastically supported, with the mothers themselves taking responsibility for the day to day management of the group.
- The Torfaen Borough plans to open a community-based drop-in centre which will provide yet another opportunity for the project to become part of community life.
- The future of the project is not assured due to shortage of funding but the foundation for a successful program has been established and there is a strong commitment for its success among professionals, volunteers and the community.

Conclusions

The three community parenting projects described in this chapter have demonstrated the ability of communities to work with professionals on shared goals. However, the long term benefits of a program cannot be evaluated in its first year by accepted medical model research. Community projects which are evidence based need to be run for at least five years to see measurable effects. Evaluation of the South Wales programs continues. To date such evaluations have been based on subjective and anecdotal data, but the beneficial effects are evident from the results of client satisfaction surveys.

Keys to the success of developing a parent to parent program

"*The community and volunteer mothers of De Madres a Madres taught professionals that at least five years is needed to initiate, develop, and sustain a community-based model for primary care.*" (McFarlane 1996)

We believe that these three programs illustrate the following keys to success developing a similar program:

1 *Find someone with local influence who really believes in this sort of program and continues to give it the support needed to produce positive outcomes.*

2 *Take time to research what the community actually needs before a model is devised for implementation.*

3 *Think it through carefully.*

4 *The co-ordinator should have adequate time to establish links with the community and needs to inter-link a community development approach with one that implements public health policies.*

5 *Ask for constant feedback and evaluation. Be prepared to change!*

6 *A minimum of 5 years funding is essential for evidence-based evaluation.*

7 *Try to make it a positive, empowering experience for everyone involved.*

The programs need to be supported by managers with courage and vision, who have a commitment to community development. They should also have an understanding of

evidence-based practice. Mechanisms should be in place to ensure that community needs are represented at commissioning level.

The health visiting team is in a unique position of having access to whole communities and adopting a practice of developing positive community interaction.

Managers, professionals and volunteers working within a community development model will become empowered and achieve positive outcomes. There will be a shift in power to the community, but this is beneficial for all concerned.

Recommendations

1 Work with local and central government to develop support for volunteer parenting program.

2 Enable local health visitor services to actively support the parenting programs.

3 Encourage the integration of the local parenting program with other initiatives to develop self-sustaining communities. Parent help is a key to community self-help.

4 Establish local and national parenting program forums allowing parent projects to network and share best practice ideas.

5 Use existing training materials that have already been developed as well as expertise acquired setting up these programs to assist in the start up of other volunteer parent programs. Do not reinvent wheels.

The future

The three projects within the Gwent area, which we have described, have worked closely together through joint workshops and regular meetings. This has allowed the project members to explore new ideas and developments around practical issues. This sharing approach has been extremely beneficial to individual members of the projects and to the development of the programs. It is hoped that the three programs will continue to be supported by the local authorities and central government and that this will result in communities working more closely with professionals in the future. As such, they can provide models for parents and communities everywhere.

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8. NATIONAL PARENT SUPPORT PROGRAM IN IRELAND

Chris Sheridan, Joan Roberts, Aidan Warner, Anne Coyle and Pat O'Rourke

This contribution looks at the development of the community mothers initiative in four Health Boards in the Republic of Ireland in the 1990s. The social and economic conditions and policy initiatives which impacted on the development of the respective programs at the time are examined. The structure and operation of individual project are analyzed along with their shared development. While each project has to adapt to its local environment and conditions there is an emphasis on them to working together to develop a coherent and integrated program. The core values which underpin this integrated development are outlined with particular attention given to the central role played by the participating voluntary agencies. There is a strong commitment and emphasis on ensuring that the program is community based and driven.

Introduction

The period from 1986 to 1996 was one of unprecedented change in the Republic of Ireland. The development of the National Parent Support Program took place against a backdrop of significant changes in Irish society particularly in relation to changes in demographic patterns, the care of children and women's participation in the workforce. At the start of the 1990s there was also a greater openness in addressing social problems particularly in relation to the care of children and families.

Clear responsibility for the development of child care and family support service in Ireland rests with eight regional health boards.[1] In 1992 initial approaches took place between a number of health boards and the Van Leer Foundation aimed at developing a program based on the Community Mothers Program which had been developed by the Eastern Health Board. They were the Midland, the North Eastern and the Mid-Western Health Boards. This new program would, like the Community Mothers Program, involve experienced parents visiting new parents. The emphasis of the new developments was to be on a program not only being community based but also community led.
The Southern Health Board set up a Child Development Project which incorporated a home visiting dimension to a wider program. They felt that the development of such a program offered a possible way of developing an effective response to their problems.
We will describe the development of the programs in the first three Health Boards first. The development of the Cork based program will be dealt with separately.

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Some background information

In the period 1986 to 1996 Ireland was caught between two approaches to the role of women in the workplace.

1 The Irish Constitution's view favours mothers staying at home: the State recognises that by her life within the home, woman gives to the State support without which the common good cannot be achieved (Article 41.2.1). Up to 1973 women working in the public service had to resign when they got married.
2 Government supported the Second Commission on the Status for Women's view that all women should be enabled to work outside the home should they so wish. This was, however, hampered due to the lack of adequate child care facilities.

There were huge demographic changes. Flanagan and Richardson in 1992 described what happened as follows: "*Overall, trends in family formation point to the evolution of older parents, smaller families, less of whom are based on marriage, a higher number of lone parent households resulting from divorce, separation, non-marital births and finally the development of reconstituted families.*" The number of children per woman declined from an average of four to 2.17. Families with seven or more children have more than halved from 17.952 to 7.850 and the number of births has decreased from a peak of 74.388 (1980) to 61.620 in 1986 to 48.530 in 1995. There are also more children born into single parent families with the number of births to unmarried mothers increased from 9.6 percent (1986) to 22.2 percent of all births in 1996. Marital separation also increased dramatically. According to the census figures from 1986, 37.245 persons described themselves as being separated. This rose to 55.143 in 1991 (CSO 1986, 1991). There was concern at the numbers of young children being taken into care by the health boards.

	Number	Percentage
Up to 1 year	921	29.8 %
1 years < 2 years	308	10.0 %
2 years < 4 years	488	15.8 %
4 years < 7 years	520	16.8 %
7 years < 12 years	515	16.7 %
12 years < 16 years	305	9.9 %
Over 16 years	33	1.1 %
Total	3090	100 %

Table 1. Age on admission of children in care at 31 December 1992

There were also a number of other developments which placed the care of children centre stage:

- There was a significant change in the number of women with children participating in paid employment. Particularly in the poorer communities women were more likely to obtain employment, albeit mainly in low paid jobs, than men. Millar et al (1992) point out that the government's response to lone parenthood favours parents remaining at home, unlike other European countries where employment-led support policies are favoured and they argue that the latter response would improve the living standards of lone parents and their children.

- The primary focus of child care services from the 1980s was on child protection. Gilligan,1993). Almost 60 percent of children in care come from lone parent families. In a review of the provision of child care facilities in the late eighties Ireland had the worst record in the European Union (Mc Kenna 1988). Some positive developments have occurred in recent years to improve the situation, but the situation in Ireland is still very far behind compared to other European Union member states.
- A positive feature however, was a greater openness in addressing social problems particularly in relation to the care of children, helped along by some high profile child abuse cases.
- Furthermore, family life in Ireland began increasingly to resemble that of other European countries and the health boards were anxious to address the identified problems in a proactive manner.

	No. of Families	Percentage total
Married Couple	904	29.3 %
Married but living apart	692	22.4 %
Unmarried Couple	331	10.7 %
Widow/Widower	212	6.8 %
One Parent Unmarried	893	28.9 %
Other (Where both parents are dead or missing or their identity is unknown	58	1.9 %
Total	3090	100 %

Table 2. Family type of children in care at 31 December 1992

Government response

The changes which are outlined above led to a rethink among policy makers. New comprehensive legislation was approved by parliament: the Child Care Act 1991, which was fully enacted in 1996.[7] This Act represents a coherent legal framework with checks and balances in place and with three clear underlying principles: the family is usually the best place for the child, the welfare of the child must be the primary consideration and the wishes of children are to be considered. Clear responsibility is given to the health boards. And placed, among other things, a statutory duty on the health boards to promote the welfare of children in their area who are not receiving adequate care and protection. It also strengthened of the powers of health boards to provide child care and family support services.

> ***Midland Health Board***
> *The Midland Health Board serves a population of 203.000 and covers the counties Laois, Offaly, Longford and West-Meath. The program is located in counties Longford and West-Meath and carried out in three small towns: Athlone (14.551), Longford town (6824) and Ballymahon (1617). These towns have birth and fertility rates slightly over the national average.*

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Jenny Fletcher acts as the overall co-ordinator. She is responsible for the day-to-day running of the program. Elaine Keogh is the co-ordinator in Longford, with former Visiting Parent Maureen Macken working as the area co-ordinator in Athlone. The Chief Agent is Pat O'Rourke, Senior Executive Officer Community Care. This team is supported by Lindsay Adamson the manager of the Athlone Community Service Council, Sr. Calasanctus, the director of the Longford Social Services Council and Kathleen Leavey the Superintendent Public Health Nurse.

Mid-Western Health Board

The Mid-Western Health Board serves a population of 310.700 and covers the counties Limerick, Clare and Tipperary (North Riding). The program is located and carried out in Limerick city (52.024) but it targets only the public housing estates with a population of approximately 33.800. These areas have particularly high rates of unemployment and lone parenthood. The public housing estates have also been selected as a target area under the European Poverty 3 program.

The co-ordinator of the Mid-Western team is Gerry Nolan, a local social activist who is responsible for the day-today running of the work of the program in recruiting, supporting and supervising the work of Parent Visitors. Other members of this team are Liz Dunworth, one of the first group of Parent Visitors who has acted as a second co-ordinator since 1995. Pam Lamb the local Public Health Nurse from the health board. Pam also had experience of the First Time Visiting Program in the United Kingdom. Geraldine Hanna works part-time with the Health Education team of the Health Board as a parenting co-ordinator. She also worked as an adult education tutor in the local prison and in the local community, particularly in disadvantaged communities. Geraldine has acted as a training resource and developed the initial training modules on home visiting. Finally, Chris Sheridan is a community worker attached to the social work team of the Health Board. Chris has responsibility for liaison with the Voluntary Sector with particular emphasis on child care and family support service.

North-Eastern Health Board

The North-Eastern Health Board serves a population of 300.200 and covers the counties Louth, Meath, Cavan and Monaghan. The program is located in Dundalk (25.843) and Drogheda (23.848) the two largest towns in the region.
At present the program is concentrating on two large estates in Dundalk: Muirhevnamore and Coxe's Demesne.

There are five people in the North-Eastern team. The co-ordinator is Paula Gribben, a nurse with experience in adult education in public housing areas in Dundalk. She also ran a home based on support services to parents with children with learning difficulties. Lucy Rafferty, a local community activist in the Muirhevnamore Estate. Bernadette Dunleavy, the local Public health Nurse and Anne Coyle, Chief Agent and working as a Senior Executive Officer, Community Care.

Southern Health Board

The Southern Health Board serves a population of 532.263 and covers the counties Cork and Kerry. The program is located in the North West district of Cork city which is the second largest city in the Republic of Ireland. The North West district is part of a greater geographical entity - the north side of Cork city - which is one of the disadvantaged areas within the country. This is reflected in relation to levels of unemployment, imbalance of development and early school leaving age. Housing is almost totally provided by Cork Corporation, the local authority. There are approximately 35.000 people living in the target area with an estimated population of children under three of 1500. The program aims to develop innovative projects which will support families with younger children especially in the 0-3 age group.
The work of individual programs within the Child Development Project is supported by advisory groups drawn from the local community and personnel with particular expertise in relation to the programs. The project is managed by a steering committee consisting of personnel from the Southern Health Board, local schools and University College Cork.

The Southern team consists of four members. Joan Roberts acts as the program co-ordinator. She is seconded by the southern branch of the Irish Pre-school Playgroups Association where she worked as their regional pre-school advisor. Mary Curtin is the part-time secretary and administrator. She provides also, with Joan, the ongoing support to the Visiting Parents. Eugene O'Connor works with the Southern Health Board as a community worker. Finally there is Aidan Warner, also a community worker who is responsible for the liaison between the Southern Health Board and the Van Leer Foundation. Support was provided by the Early Childhood Development Unit in Bristol in relation to recruitment of the visiting mothers.

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In recent years there has been a shift from a welfare approach towards one which increasingly aims to enable lone parents to return to work. The development of state involvement in family support services has increased significantly. Prior to this these services tended to be provided in an ad hoc manner by voluntary organisations, but now partnership arrangements between state and voluntary sectors increased.

Establishing National Parents Support Program, Ireland

Before actual starting to develop the program a mission statement for a National Parents Support Program was formulated. The National Parent Support Program is a structured program aimed at enabling parents to enjoy and participate more fully in their child's development and supporting them in their role by encouragement, sharing experiences and information with other parents'. The mission statement seeks to reflect a number of elements:

- An emphasis is placed on the structured nature of the program. The group is conscious that a visiting program centred on non-professionals could easily become unfocussed without some structure.
- The aim is to place the parent at the centre of the program. The parent is seen as the expert on his or her own child. Visitors are asked to focus on the strengths of the parents being visited. Catch the parent doing something right became a catch phrase within the program.
- Too often the focus on parenting has been on problems. The program focuses on parenting as fun!
- The mutual sharing of information between parents is central to the program reflecting the view of the parent as expert.

Chief Agents, Resource Persons, Core Teams

Chief Agents

Responsibility for the initial development of the program was given to employees of the respective health boards. These employees included Senior Administrators in the Community Care Programs in the Midland and North-Eastern Health Boards and Community Worker in the Mid-Western and Southern Health Board. These are called locally the 'Chief Agents'.

Resource persons

Each Health Board selected three 'Resource Persons' who were trained by Dr. Walter Barker and his team at the Early Childhood Development Unit which is in the University of Bristol. The first training session was held in September 1992 and introduced the participants to the philosophy of the program. Emphasis was placed on the fact that the program should be community based and community led. Following the initial training session the group visited First Person Visitors and Community Mothers in England and Northern Ireland. Further joint sessions were held and finally training sessions were held for each individual team in

their own area. The programs then received financial support from the Van Leer Foundation for an initial four year period (pilot phase). All programs commenced on July 1 1993.

Co-ordinators

Co-ordinators were selected from within the Resource Persons and latterly from within the Community Mothers themselves. They were responsible for the day-to-day running of the program. In each target area a Core Team was set up. This team sought to reflect the health boards' commitment to the principles outlined above, with a strong emphasis on interdisciplinary co-operation between different elements of the health board services and between the Board and the community and voluntary sectors. In each area the work of the groups supported by Advisory Committees which are made up of professionals and representatives from the voluntary and community sectors. They played an important role in having the program accepted in each of the areas.

The core teams are committed to grounding the program in local communities with the support and backup of professional staff from different sections of the Health Boards. In grounding it in local communities an emphasis is placed on the close liaison with other initiatives in these communities and on locating the program along a continuum of care in an area in line with the principles outlined above.

The objectives of the national parent support program as agreed in 1993 are:

- to improve parent's capacity to rear, educate and provide emotional support to their children by enhancing the self-esteem and confidence of parents;
- to recruit visiting parents in the target areas and provide them with training and continuing support through a community resource unit, and
- to establish appropriate and sustainable co-operation between the community, the voluntary and statutory sectors for long term development and to provide resourcing of the program.

Recruitment of visiting parents

In the early stages of the program a lot of time was spent on recruiting parents to act as visiting parents. The recruitment process was used as a low key method of advertising the program in the respective communities. Key community activists and professionals working in the community were approached. These were processed by the core teams. In some areas written references were required. In all health boards checks were carried out on prospective visiting parents. Final decisions were made by the core teams.

Training

The groups tended to shy away from the term training. Rather they sought to enable parents to identify their own strengths and to enable others to do the same. Prospective visiting parents are asked to reflect on their own experience of being first time parents.

Much time is spent on enabling parents to internalise the philosophy of the program. It has been interesting that in identifying what they would have liked as first time parents the potential visiting parents have always come up with the same issues which are central to the philosophy of the program. This includes:

- *having someone to listen to you;*
- *being the centre of attention for a change;*
- *being trusted to become a good parent;*
- *having your views respected;*
- *having access to any information you might need.*

Following the internalising of the philosophy of the program candidates practice introducing the program to others. A major focus is placed on developing listening skills in seeking to encourage positive self esteem among the parents. Visiting parents are given information on a wide range of services in their community and on how to access these services. Particular attention is also placed on services to parents and children and adult education services.

Visiting

After the initial introduction phase the parents start visiting. The names of parents who have recently given births are received from the local health board and are matched with a visiting parent. In some situations parents refer themselves directly to the program. Each visiting parent would usually visit a minimum of three families whilst the maximum number of parents visited by one visiting parent is fifteen.

Once the people begin visiting as visiting parents they have regular supervision from the co-ordinator. There are also regular group sessions for ongoing support. Support for the co-ordinator is provided by the chief agents and support teams.

Child development project in Cork

In 1994 the Southern Health Board developed close links with the National Parent Support Program when developing its child development project. This initiative involved also the Irish Pre-school Playgroups Association and the Van Leer Foundation. Developments in pre-school and family support services tended to be more advanced in Cork than in the other Health Boards. The project arose from a series of parallel developments that occurred in the early 1990's.

1. Discussions took place to extend home visiting programs to other health boards areas.
2. A Health Status Profile undertaken by the Southern Health Board in the north-west sector of Cork City indicated amongst other thing the need to address health/development issues in relation to younger children and their parents, i.e. infant and child death, accidents, dental health and health education.
3. Since the mid 1970's innovative family support work was being developed by non governmental organisations and later supported by the health board. This was reflected in, for instance, the development of family centres and pre-schools provision. However, the focus of this

work was primarily in relation to work with children in the 3-5 age group and their parents. It was acknowledged that there was also a need to focus more specifically on developing programs for the 0-3 age group and their parents.

4 There was a recognition of the need to co-operate with other services provided by the statutory sector to young children. This was especially important in the context of the child care legislation, new emerging partnerships and the importance of the role of the consumer.

5 There was acknowledgement of the need for a community participation and ownership of programs which would have an effective impact on the health and development of young children and their families.

6 Most recently the development of the 'Early Start Program (a provision of the Department of Education pre-school services for 3-4 year olds within the primary school system) has meant that former service providers are examining and refocusing on possibilities of work with 0-3 year olds. This is also relevant for national organisations such as the Irish Pre-school Playgroups Association.

The project in Cork started in September 1994. The initial focus of the work was on the development of a home visiting program for first and second time parents. However, this development was undertaken in the context of the visiting being a part of a wider continuum of support to families with young children. To that end the child development project has developed and promoted the home visiting program in conjunction with local statutory services and the relevant non governmental organisations such as Family Centres, pre-schools, primary schools and relevant voluntary groups. This emphasis is seen as necessary and important in embedding the various programs such as the home visiting within the general family support structures operating within the sector.

The under three unit

The Under 3 Unit started in September 1995 and is an important dimension to the Child Development Project. It aims to develop an informal, educational environment where parents can come together and enjoy themselves by interacting with their children whilst at the same time increasing their knowledge and understanding of child development. The Child Development Project believes that the most important influence in early childhood development is the quality of the relationships between parent and child. This project is set up within an existing Family Centre which fosters a Montessori model of early childhood education.

Impact of the National Parent Support Program

The impact of the program has been felt in three areas: the families themselves, the visiting parents and the service providers.

1 Families

Reaction to the program from the families has been very positive. Some have spoken about how important the program has been in their lives. Many of the families have been enabled to become more active in their communities as a result of the program, for instance, attending adult education programs, parenting programs, using local crèches.

> *"I don't know what I would have done without the visit."*
>
> *"Mary's visit was my link with sanity."*
>
> *"The program helped me face up to difficulties in my life. With the information given to me by the visitor and her support, I was able to sort thing out. I owe the program a lot."*

The program has facilitated a more appropriate use of services such as the public health nursing service, social work and community welfare service by parents and others. It has assisted in demystifying and removing barriers between professionals and service users. The program has also enabled early intervention to occur in families experiencing particular difficulties. One major area of difficulty is young parents living with their parents. This is a potential source of conflict and in some cases young parents who want the program are discouraged by their parents from availing of it, while in other cases parents turn the program down because their own parents insist on them doing it. Some of the parents who were visited became visiting parent themselves.

2 Visiting parents

The visiting parents have spoken of the sense of achievement they feel in providing the service. A number of them have obtained employment and have identified their involvement in the program as a significant factor. Their role in supporting parents has given them a greater understanding of existing services and has enabled a number of them to develop effective relationships with professionals which has been mutually beneficial. The program has helped demythologise professionals with consequent benefits for the professionals themselves.

3 Service providers

The program provides an important link between service consumers and service providers through informing people about the services available and improving the understanding of what services have to offer. It also seeks to improving the understanding between service providers and consumers. The program assists in early interventions and the appropriate update of services. It provides a channel for an exchange of views about services and about gaps in service between consumers and providers. Members of core teams have been invited onto policy review bodies due to their involvement in the program.

The program networks with other developments aimed at providing support to new parents has involved networking with family resource centres, community based crèches, parent support groups, women's groups, pre-schools, home school liaison programs, community development and adult education initiatives. All of the core team and most of

the parent visitors are involved in the development of new child care and family support initiatives such as the resource centres. Members of the program are on a significant proportion of local community based initiatives particularly those with a child care or family support dimension.

Involvement of voluntary sector

There is a growing use of partnership arrangements in the Health Services which started in the late 1980s (Duffy, 1993). All four programs are located within voluntary organisations who were already funded by each of the health boards before the programs started. By implementing the programs through existing, well established community organisations it assisted in networking the program with other community based services. It also gave the programs a degree of independence. These organization have a degree of flexibility which the Health Boards themselves do not have. In particular it offered the possibility of the development of a career structure which may not have been possible in the state sector. One of the weaknesses of the voluntary sector however, has been a concern about the level of accountability. In order to address this problem clear lines of accountability were established with direct accountability going to the 'Chief Agents'.

All Health Boards are committed to maximising the involvement of local communities in the operation of the program. This is in line with the philosophy within which the health boards operate. In the Midland and Mid-Western Health Board area's umbrella Social Service Councils act as host organisations for the Program. The Athlone, Longford and Limerick Social Service Councils act as the employers of the Co-ordinators. In the North Eastern Health Board two local community crèches and family resource centres act as hosts. In the Southern Health Board the program is located in a family centre.

National exchanges

An important part of the overall development of the program has been the coming together at national level of the core teams. This models the local support sessions in each of the participating health boards. From 1995 onwards there were exchanges between visiting parents from the different health boards. These latter meetings helped to give added impetus to the community based and community led nature of the program. In a review of the program carried out in March 1997 the following key elements were agreed in all four Health Boards as representing the core of the program.

The core of the program:

- *Community based.*
- *Community driven.*
- *Home visiting.*
- *Integrated with other services with particular emphasis on the health service.*
- *Empowering parents.*
- *Focusing on the parent as expert. Emphasis will be placed on increasing parent's understanding and enjoyment of their children and on their role as the child's first educator.*
- *Focusing on parenting being fun.*
- *All giving preference toward the marginalised.*
- *Providing and exchanging information.*

Future directions

Groups with particular needs were identified as requiring innovative approaches from the programs in the different regions. These include parents of children with disabilities, teenage parents, isolated parents, parents from the travelling community, parents of teenage parents, particularly vulnerable lone parents. The program is exploring the use of group approaches to meet the needs of parents to complement home visiting activities. In Cork this wider dimension was part of the wider program from the start.

The program would wish to expand its services beyond the initial pilot areas. This will involve identifying the most suitable models appropriate to each situation. It would also seek to play major role in their regions in developing and contributing to forums which would be discussing and addressing the needs of parents with young children.

A major independent review of the four programs will be undertaken between September 1997 and April 1998. This review will seek to review the achievements of the programs, identify problems which may hamper development and provide advice on future directions for the programs. In undertaking this review a number of key questions will be addressed. These include:

- What are the inherent characteristics of these programs?
- How can the program be expanded to other groups and areas?
- How can the programs integrate most effectively with other community development and family support initiatives?

Any development of the programs will allow for project development within each area taking into account the local situation and maintaining a consistency of standards.

Notes

1 There are eight Health Boards In the Republic of Ireland. These Boards provide a wide range of health and personal social services, from acute general and psychiatric hospital care through to domiciliary care in the community. The development of health services was governed by a series of publications which outlined a number of key principles (Department of Health, 1987). Among these principles were some which were to influence the development of the national parent support program:

- the principle of subsidiarity;
- the development of a partnership approach with an emphasis on integrated development;
- participation by and accountability to service consumers;
- equity in the provision of services;
- targeting of resources to meet the needs of the most disadvantaged;
- service provision in a holistic manner.

2 Child Care Act 1991. This Act was the first serious attempt since the foundation of the State (1922) to develop a comprehensive response to the needs of children. The main elements of the Act include:

- The placing of a statutory duty on health boards to promote the welfare of children who are not receiving adequate care and protection;
- Strengthening of the power of health boards to provide child care and family support services;
- Improved procedures to facilitate immediate intervention by health boards and the Gardai (Police) where children are in serious danger;
- Revised provisions to enable the courts to place in the care of or under the supervision of health boards children who have been assaulted, ill-treated, neglected or sexually abused or who are at risk;
- Introduction of arrangements for the inspection and supervision of pre-school services;
- Revised provisions in relation to the registration and inspection of residential centres for children.

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9. MOTHERS INFORM MOTHERS: AN INNOVATIVE CHILD CARE AND DEVELOPMENT PROGRAM IN THE NETHERLANDS

Marian Hanrahan, Bert Prinsen and Yvonne de Graaf

Introduction

The aim of the Child Health Care for pre-school children in the Netherlands can be described as "*the promotion and safeguarding of a healthy, physical, mental and social development of the population of pre-school children, starting from the parents personal responsibility, by means of influencing the relevant health determinants, namely physical factors, health behaviour and relevant environmental factors, including the system of care itself.*" One objective that can be made operational is to promote at an individual and group level, the personal competence and the responsibility of parents with regard to their children, if necessary by advancing their understanding of the health condition and (potential) development of their child and by increasing their competence and health promoting behaviour (De Winter et all, 1995). It is to this objective which the Mothers inform mothers project tries to give a practical contribution to.

In general one can say that the child health services in the Netherlands are excellent. There is a high uptake of immunisation and screening programs. The average time spend on a well-baby-clinic visit is, however, only eight minutes, according to national set guidelines (De Winter e.a. 1995, Herngreen and Reerink, 1993). But for some parents that was not enough. Authors have demonstrated that the social groups with the lowest incomes, the lowest levels of education and the lowest occupational status are generally worst off when it comes to health (Townsend and Davidson, 1982; Mackenbach, 1996; Schulpen, 1996; Voorham and Van Haasdrecht 1996; Hermanns, 1996). There are socio-economic health differences known to exist in the Netherlands and the Dutch government policy paper on health emphasises the reduction of inequalities in health (VWS, 1995).

This chapter describes the Mothers inform mothers project (MIM), a network of local programs in three provinces in the Netherlands. These programs are in one large, two medium and one small town and are all carried out in deprived areas. MIM is a partnership between local communities, regional community nursing agencies and supported by the Netherlands Institute of Care and Welfare. The MIM Co-operative is the organizational framework of this partnership.

Description of the program

MIM is an innovative Dutch Early Child Care and Development Program. The program is developed as a part of the regular health services for parents and babies aged 0 to eighteen months (Barker 1992, Van de Sande, 1995). All mothers of first children are offered the program but special attention is given to reach social disadvantaged groups, members of migrant communities and children in need (Wolf, 1995). MIM uses experienced mothers to help to provide educational support for new parents in learning effective primary health and educational practices. These mothers use cheaply produced cartoons depicting different scenes, or with choices that can be made about a specific topic. A discussion about the contents of a cartoon may act as a start for exploring the mothers' attitude, knowledge or behaviour in relation to the advice she has received from different sources. The program supports also the aim of enhancing the ability of women to cope with their new born baby, of encouraging them to adapt their behaviour after receiving health educational information, increasing the number of women breast feeding, or making women feel in control of their lives. To help to plan their visits the experienced mothers use a discussion paper which they are free to use during the visit, or which they use to document their visit afterwards. The inexperienced mother will get this document at the next visit. In this way the inexperienced mother has a record of all developments which take place during the eighteen months of the program.

Development of the Mothers inform mothers program

The program is developed with the aid of mothers in Breda, a middle-sized town situated in one of the southern provinces of the Netherlands, in conjunction with the NICW and with the financial support from the Bernard van Leer Foundation. It is a community-based preventive program which is focused on healthy individual behaviour of young mothers. The locus of responsibility and unit of analysis is the individual mother and her baby (Hastings & Haywood, 1991). The mother is seen as having ultimate responsibility for her objective health status and she is indirectly ultimately responsible for the health and development of her baby.

Illustrator: Stien Sloot
Figure 1. Support of mothers

In 1990 when the first plans were being made to develop what is now the Mothers inform mothers project, the well-baby-clinic consultation tended to concentrate on the babies' health and feeding problems rather then developmental matters. The aims of the program are to support young parents with parenting; helping them to cope, staying abreast of their child development and preventing child rearing problems. The main goal is focused on mothers by trying to reinforce their sense of selfesteem and improve thereby their ability to be self-supporting parents. In doing so they, as the

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main educators, may increase the opportunities for optimal development and health for their children. MIM seeks not only to improve the effectiveness of anticipatory health education directed to parents from socio-economic disadvantaged groups, but is also directed towards refugees and displaced persons.

There were three reasons for developing the program:

- Signals from practice showed that inexperienced mothers have many questions about the development of their baby for which the health visitor has no time;
- It was felt that the predominantly working class mothers experienced difficulty in reaching the predominantly middle class health visitors. Communication problems did hamper these mothers access to health education;
- Mothers were given information from many sources, but the result was that they experienced difficulty in making choices which they felt appropriate to their own circumstances;

Due to the existence of a Community Mothers Program in Dublin an opportunity presented itself which could be an answer to deal with these signals (Johnson, Howell & Molloy, 1993). After initially looking at the possibility of translating the Irish program materials the decision was made to adapt and develop the program to Dutch circumstances. Whilst having similar aims as the Dublin program, MIM places also places emphasis on pedagogical support.

Stakeholders

Local experienced mothers are prepared to support inexperienced mothers who are poor, stressed, or feeling isolated and unsure about their infants development. They help them to use their own knowledge and instincts in order to reduce health or other risks which may impair their baby development. They volunteer their services but are paid their expenses. They liked to share their experiences with others, mainly because they had felt the need for those services themselves when they were inexperienced. These were one of the original stakeholders.

The other stakeholders involved were the nurses, management of community nursing agencies and the Netherlands Institute for Health and Welfare.

Both inexperienced mothers and the 'Kruisvereniging Breda' wanted improved health educational services. They both wanted a tailor made service suited to the needs of mothers and their babies. Senior management of the 'Kruisvereniging Breda' wished also for an effective and efficient service without loss of quality of care or extra financial input after the developmental phase. Nurses were and are interested because an effective service will give them bargaining power with purchasing agencies whilst their changing role in preventive child health and welfare services could legitimised priority setting for services directed at families in need. In their view the experienced mothers are well able to support the inexperienced mother with finding answers to simple, practical questions or problems. But not all nurses think that way. Some nurses think that the involvement of experienced mothers in preventive child health services could possibly undermine their professional expertise.

Method

The program starts early, ideally just before confinement, and lasts until the baby is 18 months old. The inexperienced mother receives monthly visits in her own home. The

experienced mothers come from the same target groups that they serve. They are well equipped to answer the questions posed by expectant and new mothers. They also have an understanding of what the new mothers are going through. An experienced mother of twins for example is matched with an inexperienced mother of twins. Similarly with mothers who breast feed their babies, or mothers with a baby suffering from a severe allergy or born prematurely. The experienced mothers adapt the MIM-materials to suit the individual mother they visit. Both live in the same neighbourhood and have usually similar backgrounds. The experienced mother will use her own standards and experiences as a mother to support and assist the young mother. In doing so she will give as little advice as possible. Rather she will support the young mother in finding her own answers to day to day questions and in resolving problems as they arise. The program has evolved multiculturally in approach, and attitude and there are strong indications that the targets groups are now being reached.

Results of action research

Action research was carried out simultaneously with the developmental phase of the program (Wolf 1995). The target groups for the Dutch program '*Mothers inform mothers*' come from lower social economic groups including migrant-, drug addicted-, teenage- or single parents. The action-research study chose to emphasise the qualitative evaluation of the program. This increased the possibility of using its results to improve the program's implementation by adjusting the content, the tools employed and the methodology of various parts of the program. The result is a transferable program for support in child rearing and health promotion. It would be untrue to say that these results come from an experimental research design as promoted by the WHO (Gepkens & Gunning-Schepers, 1994). Descriptions of MIM-effects are accounts of the program results as they are perceived by experienced and inexperienced mothers. They represent an indication of possible program effects. The results were instrumental in changes within the program, and in the content and lay-out of program instruments. Up to now the program has been instrumental in enhancing the quality assurance activities from a professional perspective in Breda.

Inexperienced mothers

There proved to be two types of women encountered at the well-baby-clinics: women of an independent disposition and less independent women who welcomed as much advice as possible. Not every mother feels the same need for information, and every mother uses the information differently. It is important that health visitors and social paediatricians gear the information and education they provide to the individual needs of mother and child. Some mothers have a strong need for advice, others may want their existing maternal skills to be considered. In either case, client-oriented advice can stimulate self-reliance and break the spiral of dependence between parents and professional experts.

Some inexperienced mothers stated that the program caused them to treat their children more differently than they had imagined before starting with MIM. The systematic attention to the development of the baby made mothers more sensitive to the incremental steps in many areas at which the child's development takes place. The mothers themselves spoke of being "*more aware*" and "*giving things more thought*". The program tools, together with the monthly recurring topics discussed seem to have made mothers more 'active' with regard to their children's upbringing. Several mothers said that they "*paid more attention*" to

the incremental developmental steps of their baby. This could conceivably have a positive effect on sensitivity and responsiveness within the parent-child relationship. The results indicated that inexperienced mothers showed increased self-sufficiency and more attention to the development of their child. They felt more independent and were better able to make their own choices. Tentatively we would suggest that the program is responsible for this increase in self-sufficiency and self-reliance. These results show that mothers of different social backgrounds benefited from the program.

Experienced mothers

The experienced mother proved to be an answer to the two problems, which had given rise to the start of MIM, lack of receptivity and insecurity about child rearing. A clear understanding of the range and type of questions from parents to the experienced mothers has influenced practices at well-baby clinics. For example, health educational messages are described in a standardised manner and the program plays its own supportive role in delivering the information. All experienced mothers make a clear distinction between health educational advice with a link towards screening activities (inocculations, sight, physical development) and pedagogical support (importance of mothers' role in speech and cognitive development, talk and play with the baby). The skills and knowledge of experienced mothers living in same areas are utilised. As far the experienced mothers were concerned, their increased self-sufficiency manifested itself in the fact that they became more active in social activities (other voluntary activities, new educational opportunities, employment) within and outside the program.

Use of program tools

The most popular instrument turned out to be the experienced mother herself, then the program sequence of cartoons, followed by the discussion paper which the experienced mother uses to document and plan her visits. This order reflects the strength of the program, which is built, as it were, upon experienced mothers. The popularity of the experienced mother did not mean that the other tools were under appreciated. The experienced mothers and cartoons (see figure 2) in particular were viewed as being complementary. The combined use of cartoons and an experienced, practical expert is an entirely new method within parent and child health care. The method is based on the theory of health education focused on disadvantaged groups, which claims that such information method benefits the use of existing social networks (Freire 1989, 1992, Tenhaeff 1994).

Figure 2. A cartoon.

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The discussion paper was sometimes thought to be difficult, but this did not mean it was unwelcome. Child development topics were especially appreciated, as was the fact that specific attention was also being paid to the mother. This last discussion topic was in most cases seen as a personal concern from the experienced mother, while in actual fact it formed part of the discussion paper. The women were able to distinguish between parent and child health care questions needing professional nursing or medical expertise and questions suited to be answered by the experienced mothers. This showed that most women correctly understood MIM to be an addition to the well-baby-clinic with regard to medical and other questions not requiring medical or nursing expertise. Notably, most women drew a clear distinction between essential professional expertise and skills, and the self-reliance which a mother can develop herself.

Health professionals

Interviews with health visitors and social paediatricians revealed that long association with the program had made them increasingly convinced of the advantages of approaching mothers as experts on their own children. The advantages of an alternative professional attitude had gained increased recognition. This brings us to the conclusion that if members of the target groups are seen as active participants this will change the role and position of an expert and create a better intervention climate.

Results of recent process evaluations at program sites

In each of the program sites the program is supported by a specialized community nurse who also participates in the program as one of the experienced mothers (Hanrahan, Prinsen & de Graaf, 1996). This nurse is paid by the community nursing agency. To facilitate the start of each program at a different site, the community nursing agency will look for money from the local municipality, charitable foundations and/or insurance companies. The nurse is responsible for recruiting both inexperienced and experienced mothers to participate in the program, and match them up according to educational or other significant common background variables. She then prepares the experienced mothers for their voluntary work. She facilitates the monthly group meetings organized by the experienced mothers themselves. During these meetings experienced mothers share their experiences and discuss ways and means of enhancing program proceedings. They will also identify conflicting advice given by members of the well-baby-clinic-teams, or other signals they encountered during the home visits from the inexperienced mothers. Other tasks performed by the nurse are ensuring the ongoing quality of care, representing the program at workshops seminars or conferences, and having regular meetings with the members of the well-baby-clinic-team. Usually the representation of the program is done in co-operation with one of the child health care service managers and one of the experienced mothers. The experienced mothers all work under the aegis of the volunteers' charter in which all privileges, insurance, rules and regulations are outlined.

At present there are four program sites in place: Breda, Dordrecht, Sneek and Uden. Their finance comes from different sources. In Uden the association has re-arranged budget parameters with permission from the regional health insurer. Dordrecht receives a subsidy from the local municipal authority. Sneek is using funding from a charitable foundation and a municipal subsidy. Breda itself has funded the continuance from efficiency measures. Indications are that, in the long term finance can be found within different organisations by the use of similar efficiency measures.

Breda

Breda has 130.036 persons living in the city, 6476 of them of a foreign nationality. There are approximately 1447 births per year (all births). The program is established in deprived areas of the town where unemployment ranges from six to over 10 percent. The number of single parent families is 5187 and of these 4122 are headed by women. The program was initially offered to the original target group of 'difficult to approach' mothers as well as to 'insecure' mothers. In practice, every first-time mother in the participating housing estates can participate in MIM. A strong recruitment drive was used to approach the target groups. In January 1997 forty-two experienced mothers were visiting 105 inexperienced mothers. Some of the mothers visited are experiencing post natal depression, have had twins, a baby in an incubator, or have a baby with Down syndrome. The largest group of inexperienced mothers with whom MIM works are of Dutch origin. A relatively large group of foreign women also take part. They are predominantly from a variety of non-European countries. There are also a considerable number of people with refugee status (Asia and Africa) and migrants who originally came from Turkey or Morocco. From 1994 there was a steady influx of people from the former republic of Yugoslavia. Initially the women from lower and upper income bracket were less successfully reached than those in the middle income bracket, but this has changed over time. Preliminary results show now that mothers of different social backgrounds participate in the program.

Dordrecht

In January 1997 there were 26 experienced mothers visiting 65 inexperienced mothers who lived in one of the most deprived parts of Dordrecht, a town with 114094 people. Approximately seven percent of these have a foreign nationality. Unemployment is 10.4 percent and there are 4268 single parent families. The program is still in its infancy when compared with that in Breda. The program is experiencing some difficulty in keeping sufficient experienced mothers for visits, as they are inclined to find paid employment and leave ironically due partially to their involvement in the program. Plans are being developed to experiment with a group approach of MIM with a view to solving this difficulty.

Sneek

Between December 1995 to October 1996 eighty-two children were born in participating parts of Sneek. Of these, twenty-three babies and their mothers participated in the program. An additional three mothers were invited to join the program while living in other areas of the town. One of these twenty-six mothers participates due to having had a second baby. Five mothers stopped prematurely with the program due to family circumstances or by not keeping appointments. There are eleven experienced mothers visiting. Most of the inexperienced mothers (15) went to schools at vocational education level, nine to secondary school and one to college. From one mother the level of formal schooling it is not known. From the eleven experienced mothers there were three who finished vocational education or training, six went to secondary school and two to college. Twenty-three inexperienced mothers have Dutch nationality (three of them have Turkish parents), the others come from Germany (1), Peru (1) and Egypt (1). Six mothers reported no specific problems. Others do. Some of the experiences that the two groups of mothers have in common are: mental or physical health problems (4), difficulties with relationships or feelings of isolation (8), very young (1), drug use (1), aged 40+ (1), financial difficulties (1), difficult confinement (4).

Uden

In Uden a process evaluation was carried out over the period September 1st 1995 to June 15th 1996. The whole town participates in the program, which means that it is not confined to deprived areas. Approximately 430 children are born each year in this town and in the evaluation period 61 first born children were born. The aim of the organization was that one third of these babies and their mother should participate in the program, and this goal was reached.

There are 20 inexperienced mothers participating in the program, visited by eight experienced mothers. Seventeen of these inexperienced mothers were recruited in the prenatal period while the other three consented to participate after the birth of their baby. Most of the women (11) have completed vocational education, six have vocational training, and three finished college. Only two were in receipt of unemployment payments, the others being in paid employment. In seven families both partners were working outside the home. Four mothers were born outside the Netherlands (UK, Surinam, Turkey and Zaire). Eighteen mothers visited perceived a problem. They were: born outside Netherlands (4), twins (1), difficult birth (2), lone parent (1), isolation / insufficient social support network (3), 'cry baby' / eczema (2), premature birth (2), unplanned pregnancy (1), coping with the after effects of IVF (1) and frequently absent partner (1). It is expected that a full evaluation will be carried out at the end of the eighteen month program period.

Every participating organization is offered support. The preparatory period usually lasts one year. The year starts with the discussions on management level and the time scale and planning stage for preparatory activities prior to the actual start of the program. After that, special attention is given to the role and function of the nurse who co-ordinates the program locally and is specialized in child health and welfare. The professional support to implement and support the nurse is given by a pedagogue (developmental psychologist) and a health educationalist. Empowerment activities need to be supported by an empowered employer and care provider. When a mother is seen as an expert, the co-operation, participation and partnership between her and the professional employees (doctors and nurses) needs to be addressed. This means discussions on different levels in the organization and guidelines for practice.

Strengths and weaknesses of MIM

From our discussion with directors and others we have identified the main strengths and weaknesses of MIM. There are some strengths in the program as follows:

- it is developed in partnership with the target groups (disadvantaged mothers);
- it is developed as a potential integral part of the child health service;
- its potential reach towards target groups is high;
- the action research experiences and the results of the process evaluations are encouraging;
- potential effect in lowering social-economical health differences seems to be present and,
- MIM intervenes and interacts with mother/baby's health and welfare determinants.

There are also a few weaknesses and problems to overcome to get the program totally integrated in the statutory preventive child health package.

- Social paediatricians have a strong strategic position and there is not much body of

knowledge from the nursing profession to warrant face value acceptance.

- Epidemiological research or an evaluation on the effects of the program has not yet been carried out. International research results concerning early child care and development programs are available (Olds et all 1993, Johnson, Howell & Molloy 1993).
- No study on the cost-effectiveness of the program has been carried out.
- The financial basis of the program within current budgets of health care agencies is difficult. Discussions on the positioning of the program is ongoing due to the presence of some pedagogical components in the program. At present a positioning of the program within preventive child health care is being advocated by the participating organisations. Preventive health is paid through general health contributions and child care activities which are part of the welfare system are funded by local authorities. To receive additional money to pay for the starting-up phase of MIM in a new organization, the program has to compete with many other projects and activities.
- Reaching mothers living in multi-problem circumstances is slow and time consuming and getting results within a relatively short time is difficult.

MIM is developed as an additional but potentially integral part of the regular statutory parents and pre-school children's health services in The Netherlands. It is envisaged that its effectiveness will be tested so that with its results the decision to fund the program as an integral part of the national parent- child care/health services can be made. It will be possible to establish the costs of the program, but we would be unable to express the health effects in non-monetary units such as life-years gained or quality-adjusted life-years gained.

MIM type programs also empower parents in such a way that they are not only active with their own children, but starting also activities to change the physical environment in which they live. In MIM we see multiple outcomes and we are targeted at many beneficiary groups. Empowered parents may ask for specific health services, improved educational facilities and income support beyond what is currently the norm.

As resources are fixed, areas of change requiring more resources will be funded from service reductions within the same program or within another program. We hope that as a result of research-findings and innovations in child care the program might be incorporated in the statutory services by the year 2000.

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PART III: LESSONS LEARNED

10. RESEARCH TO FIT PRACTICE: INNOVATIVE ACTION RESEARCH IN HEALTH PROMOTION

Maria Koelen and Marian Hanrahan

Community based early childhood programs are carried out in a field setting, in which it is difficult to control for extraneous factors. There are problems with research design, but also problems in studying the effectiveness of community based childhood development programs. However, problems are there to be solved. There are possibilities to evaluate the programs using a combination of techniques. We discuss these problems and we offer a possible solution.

Introduction

In the past decade a wide array of community based early childhood development (ECCD) programs have been designed. The programs aim at the empowerment of adults in their role of parents and hope to lead to the prevention of psycho-social problems in children caused by negative experiences in early childhood. The focus of these programs is on supporting the family in its own home-environment, trying to bring about a change in that environment, which can be expected to have a long term beneficial influence on the child's potential (Barker & Anderson 1988). The philosophy underlying these programs relates to the concept of health promotion, that is, the process whereby individuals and communities are able to take more control over their own life and health, and the environmental factors that affect it (WHO, 1986). Health promotion basically is a complex operation, demanding multiple strategies, and it is an intersectoral concern. It demands co-ordinated action of governments, health and other sectors, non-governmental and voluntary organisations, local authorities, as well as of industry and the media (Kickbush, 1986). This point is very well expressed in five principles of health promotion (Ashton & Seymour, 1988):

1 *health promotion actively involves the population in the setting of every day life rather than focusing on people who are at risk for specific conditions and in contact with medical services;*
2 *health promotion is directed towards action on the causes of ill health;*
3 *health promotion uses many different approaches that combine to improve health, including education and information, community development and organization, health advocacy and legislation;*
4 *health promotion particularly depends on public participation;*
5 *health professionals, especially those in primary health care, have an important part to play in nurturing health promotion and enabling it to take place.*

As in health promotion in general, ECCD programs are working for and with individuals rather then on them, in the setting of everyday life. Intersectoral collaboration and

community participation are essential factors. Parents are seen as the experts on their own child and are encouraged to solve their own problems in child rearing (Johnson et al., 1993). In many of the programs health professionals such as paediatricians and community nurses are involved, but also lay-people. In fact, most of the programs use experienced volunteer mothers instead of health professionals to give support to first child parents in rearing their children.

Problems in research

Although the programs all have their specific objectives, they commonly strive for a better social and health situation for the children and their parents.
Showing results is of major importance in convincing others that the programs are worthwhile. However, to prove the effectiveness is more easily said than done. Generally, outcome evaluation of health promotion programs encounters many difficulties in meeting the norms of conventional empirical scientific research, the so called sound scientific research. Due probably to this, hardly any fully evaluated programs are found in literature (Vimpani, Frederico & Barclay 1996).
In the tradition of sound scientific research a researcher is more or less obliged to choose a quantitative approach: collecting large amounts of data and analyzing those data with sophisticated statistical procedures. In the implementation of interventions researchers have to be aware that nothing else will happen than planned, because this will interfere with the research paradigm and, as a consequence, one cannot make any proposition about what has actually caused eventual observed changes. However, ECCD programs are carried out in a field setting, in which it is difficult to control for extraneous factors. These factors comprise a severe threat to the internal validity of the research.
Internal validity refers to the approximate validity with which a relationship between the interventions and the eventual gain in health and social well-being is assumed to be causal. For example an observed effect might be due to an event which takes place between the baseline and follow-up measurement, but which is not based in the intervention (history). In order to overcome such problems an experimental design, with pretest-posttest and randomly assigned experimental and control group is required, trying to control as much as possible for interfering variables. A particular practical problem however is to find comparable groups. Parents cannot be randomly assigned into an intervention and a control group in the same living area (Barker & Anderson, 1988). Neither can parents and their children be isolated from external influences like media, other health care services and so on.

In the most ideal situation a quasi-experimental design can be used (Cook & Campbell, 1979), where the control group is selected on superficial similarity, creating additional problems for internal validity. For example, there might be differences between the composition of the experimental and control group (selection). In addition, the specific characteristics underlying the philosophy of the health promotion programs interfere with a sound scientific paradigm. We have experienced this with the SUPER-project, a study on nutrition promotion, based on the principles of health promotion, in which six European Healthy Cities co-operate (Vaandrager et al., 1993). The project started using a quasi experimental design, selecting an experimental and a control area. The central place for action would be the supermarket. According to the principles of health promotion, several professionals and volunteers from different institutions working in neighbourhood areas, including citizens, were involved. In the planning of activities they came up with

many good ideas, much better then we could have ever thought of from our academic position, also activities which should take place in settings like schools, neighbourhood centres and street fairs.

It was a difficult situation, a conflict between scientific method and practice: "*how to find out which action leads to what consequences?*" However, from health promotion point of view it was the best that could happen: participation, enthusiasm, collaboration, every-day life situations. After careful consideration we opted for the health promotion principles.

The problems mentioned so far all relate to the research design. But there are other problems in studying the effectiveness of community based childhood development programs. Firstly, in prevention studies the selection of health behaviours is determined by state-of-the art understanding of the role of behaviour in the aetiology or prevention of illness (Anderson, 1988). However, the appropriate level of different behaviours for good health are quite often subject to debate (Koelen, 1988). In the field of psycho-social youth problems the same problem is at stake. According to Hermanns (1997), it is possible to isolate a large number of factors that threaten child rearing and child development, where risk factors can be found in the generic make up of the child, in the characteristics of the parents and in the context of the child's family. However, Hermanns comments, it is not so much each of the factors leading to problems, but, rather the cumulation of risks.
Secondly, the programs are preventive in nature, and so are difficult to measure. There is no way of knowing for sure if outcomes would be similar if no intervention took place. Moreover, effects of ECCD programs are especially expected on the long term. Measurement therefore requires longitudinal studies, but these require a lot of money, usually not available in health care. In addition, programs not only aim at changes in individual behaviour; changes in the physical and social environment are believed to be equally important.
Altogether, it means that the area under study is quite complex and complicated.
Traditional research models do not fit with practice. Traditional research models are based on the wish to discover, predict and control natural phenomena.
It is a process of reductionism, which involves breaking down components of a complex world into distinct parts, analyzing them, and making predictions based on interpretations of these parts (Pretty, 1995; Chandler, 1992). This breaking down, however, opposes the holistic nature of health as we would wish to see it in health promotion. As Ashton (1988, p. 192) states: "*Above all health promotion is about synthesis; about holism rather than reductionism ..*". Community programs assume that there is a synergy among components, with the whole being greater then the sum of its parts.

Is there a solution?

Research in health promotion, regardless of the focus (e.g. nutrition, healthy persons, child development) has special reason to consider a more balanced approach in the selection of variables and of research techniques. Health promotion not only deals with the explanation of certain phenomena, but also has to solve observed problems and to study the processes of achieving change.
Community based prevention programs involve an ongoing process of decision making that requires a flow of regular inputs rather then a one-intervention evaluation situation. Therefore, a combination of research techniques is required. As far as the measurement of knowledge and attitudes is concerned, scientifically validated instruments can be used.

However, the route through which positive outcomes are to be achieved is rather complex, not only related to individual factors, but also to a great extent to social, cultural, organisational and economic factors. In addition, programs are intended to become institutionalised: projects should be incorporated into a structured and often highly formal system. It refers to practices, relationships and values that become permanently entrenched in individuals, groups, organisations, and the community at large (Bracht, 1990). Changes in these spheres are quite often not easily expressed in numbers.

As mentioned before, the principles of participation and collaboration are essential in community based health promotion. The community is the focus of both action and research, and, as McQueen (1991) states, there should be a dialogue on equitable basis between researcher and community. Participation and collaboration are not only essential for health promotion activities, but also for health promotion research. Participatory research offers the opportunity not only to create scientifically validated knowledge but also to benefit from the knowledge by experience.

Criteria for evaluation of research

At present, little information is available on effectiveness of community based preventive child health programs. When conducted, the studies focus almost exclusively on changes in children, as though this occurs as a result of some short-term impact of intervention, rather than being the product of a slow process of changed interaction between parents and children, deriving from the deeper insight gained by the parents into their own potential (Barker & Anderson, 1988; Olds et al, 1993). In addition, data about the conditions for community based programs and the processes that take place are equally important to study but are, up to now, highly neglected. For example how to find out about the influence of programs on the family environment, in which way are the programs influenced by the quality and the organization of health care and vice versa. The previously mentioned characteristics of the research setting may be due to this gap.

Research conducive to health promotion should be practice oriented and, due to the nature of health promotion, should also be participatory in nature. However, the methods used in practice oriented and participatory research are often more qualitative than quantitative in nature. Although the practical value of the results may be clear, the question remains whether the findings of such inquiry are of good quality. How do we know that our findings are true? How certain can we be that the interpretations of results reflect the 'real situation' and are not biased by the researcher? How do we know that they are scientifically relevant? That is: do they have any predictive value? Can we generalise the results to other situations?

It is commonly asserted that practice oriented and participatory methods constitute inquiry that is undisciplined and sloppy, quick and dirty, of poor quality and no more than second rate work. Conventional research uses four criteria in judging confidence and applicability of the findings: internal validity, external validity, reliability and objectivity; criteria based on the ground assumptions of the traditional research paradigm (Cook & Campbell, 1979). From our point of view these criteria are difficult to measure and difficult to meet. This does not mean that data from practice oriented and participatory research are not reliable or that they are irrelevant from scientific point of view. In a paper that has been published elsewhere (Koelen & Vaandrager, 1995) we described six criteria on which the results of research can be judged. The criteria are based on the

work of Caplan & Nelson (1973), Guba (1990), Chandler (1992), Engel & Salomon (1994), Pretty (1994), and, perhaps more importantly, on the underlying principles of health promotion. The criteria pursue the route of planning, implementation, adjustment and reconsideration of health promotion activities and follow the line from practice to theory.

Continuous collaboration and debate

Community based health promotion projects aim at the involvement of a wide range of actors. It demands co-ordinated action from (national and local) governments, the health, social and economic sectors, research centra, and volunteer organisations. Each of them has its own specific domain of knowledge and information, but also its own philosophy, objectives, standards, need for protection of its domain and its own finite horizons (Koelen and Brouwers, 1990).

In collaboration between all those actors the focus is on cumulative learning by all participants. Exchange of ideas and debate about differences leads to sophisticated information and definitions of the situation at hand and gives insight in situations asking for improvement. The result can be a research agenda agreed upon by all participants, in which they recognize their own position and in which they feel involved.

Triangulation

Triangulation refers to a cross-check of information, using multiple sources, multiple methods and multiple investigators. Multiple sources refers to the use of multiple copies of one source (for example interviews with members of one social group), or to the use of different sources about one topic (for example interviews with parents, health and welfare professionals working in a community and volunteers about perceived problems in child rearing). Multiple methods refers to the comparison of results derived from a range of methods; for example, comparing the results of observation in schools with the results of interviews with parents and group discussions with health care personnel. Once a proposition has been confirmed by one or more methods, the uncertainty of its interpretation is greatly reduced. The idea of multiple investigators is especially strong in participatory research, with those involved in activities also involved in the inquiry. A mentioned before, it requires a variety of professions, backgrounds and standards, which increases the range of perspectives and biases. When the participants agree on interpretations of results, the threat of biased interpretations is much less.

Participant checking

Participant checking actually involves the feedback of interpretations and conclusions drawn by the researcher to the people with whom the original information was constructed. The objective is to test the data, interpretations and conclusions. If the reconstructions by the researchers are recognized by the group of participants as adequate representations of their own realities, the credibility of the findings is established. Participant checks can occur both during the course of interactive analyses and inquiry, and formally in presentation meetings towards the end of the research. Participants have the opportunity to hear a summary of what investigators have learned and constructed, investigate discrepancies and challenge findings, and to volunteer additional information.

Differing views about the interpretation of results

In participatory research a wide range of actors is involved, not only in gathering information but also in the subsequent analyses and interpretation. Discussions of the

Participation of mothers and professionals — photograph Clementine Sandison

findings and their meaning from different perspectives results in some common interpretations but, can also lead to disagreement.
Interpretations with a high level of agreement can be considered reliable, while disagreement should lead to further inquiry.

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All these steps so far are essentially parts of the working process of health promotion. The benefit for research is that the trustworthiness of results is increased. The steps serve two goals: they provide the criteria against which the information can be judged, much as statistical analyses provide grounds for judgement in conventional methods, and therefore provide a sounder basis for developing working programs and agendas. Secondly, they motivate those involved to take action and to implement the desired changes. This action includes local institution building or strengthening, so increa-sing the capacity of people to participate and to initiate action on their own.

The forum

So far, we stayed more or less 'indoors' in the community under study. The practical relevance may be clear, but the steps are a basis for scientific validation as well. More certainty about the value and validity can be achieved by external presentation, which gives the opportunity for external checks. For example, in the previously mentioned SUPER-project, annual business meetings are organized where all participating cities present their recent research, with critical exploration of aspects of the inquiry that might still be implicit in the minds of the individual researchers and subject to bias.

Multiple cases

With multiple cases we mean parallel investigations in different settings. They are essential as they can demonstrate replication. Experience is affirmed if other research teams proceed with parallel investigations using similar techniques and come up with similar results.

The SUPER-project is an example of a multiple case study. Conducting comparable studies in different situations has the potential to draw conclusions about the quality of achievements and the processes in force in community based projects, but also about the utility of (new) research techniques. This offers prospects to develop strategies which are useful in other communities. Multiple case studies provide a basis for the application of the results to other situations, and that is exactly what is meant by the criterion of external validity.

Concluding comments

In this paper the difficulties in meeting the norms of conventional empirical scientific research in community based health promotion programs have been addressed. The difficulties strongly relate to the nature of health promotion, involving multi-sectoral collaboration and public participation in problem definition, planning and implementation of activities. Practice oriented and participatory research is a way to reflect the dynamics of society into the dynamics of social sciences, which is not only good for the people subjected to a program, but for the development of new theoretical perspectives as well. We have argued that, despite the prevailing conflict between scientific method and the needs for health promotion, it is indeed possible to make relevant contributions, both to practice and to science. In case of community based preventive child health care programs there are several groups willing to learn from each others experiences. An agreement to follow a comparable workplan and a comparable line of research increases the value of the individual program efforts.

We propose an integrated evaluation model addressing process evaluation, theory building and outcome evaluation using a five-tiered approach based on the work by Jacobs (1988) and Van Driel, Keijsers, Zaal & Guttinger (1994):

1 In the pre-implementation stage the documentation of the need for a particular program in the community, the demonstration of the fit between community needs and the proposed program and the provision of 'data-groundwork' are described. This includes the basic characteristics of the proposed program which is based on the results of a community needs assessment.

2 Accountability is important. An evaluation at this level is to document the programs' utilisation and penetration of the target groups. It will enable the agencies to justify and increase their current expenditure.

3 Clarification is essential in which an attempt is made to inform staff and improve the program. Basic assumptions of the program are tested such as what kind of service for whom and by whom. It will also clarify and (re)formulate the programs mission, goals, objectives and strategies.

4 Evaluations provide information to improve the program and to document the programs' effectiveness. The outcomes are examined, deriving measurable indicators of success for a majority of outcome objectives, deciding on data analysis procedures, assessing differential effectiveness among individual clients and assessing awareness among individual clients. And finally;

5 The impact of the program is measured. It will contribute to knowledge development in the substantive field of child development, family process, organisational theory, and/or to the refinement of the evaluation process. It will produce evidence of differential effectiveness among alternative program approaches, and to suggest program models worthy of replication. Tasks include de delineation of specific objectives that are to be achieved, presumably through the accumulation of short-term objectives' success, identification of measures that can assess enduring and / or lifestyle changes among participants, and the development of an evaluation plan that reflects common understandings among evaluator(s), program participants and program personnel.

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11. INCREASING COVERAGE OF PROGRAMS FOR CHILDREN: APPROACHES, STRATEGIES AND CONCEPTUAL ISSUES[1]

Nico van Oudenhoven and Rekha Wazir

Introduction

In this chapter we review the key issues and methodologies involved in increasing coverage of effective projects and programs for children. It is noteworthy to mention that in the far-ranging discussions on the type of programs we are dealing with, hardly any attention is given as to how to replicate them and thus reach larger numbers of mothers. Yet, from a policy point of view, this is one of the most important questions. If these mothers and their children benefit from being part of community based early childhood and care program would it not be good policy to extend the program to all mothers of the target population? And if this is not feasible for programmatic, financial or policy constraints, should we not review the principles underlying these programs?

Replication has been extensively debated in the non-profit sector in the United States.[2] The other major arena for such discussion is the sphere of development where there has been also an increasing concern with widening coverage of programs and interventions. This issue has universal relevance and appears high on the agenda of donors and implementors in both developed and developing settings. Unfortunately, these discourses often remain compartmentalised with little or no acknowledgement, cross-referencing, cross-fertilisation or exchange. It is remarkable that even the literature emanating from each side shows little knowledge of or interest in the main thinking and trends of the other. This paper takes a first step in exploring the linkages between these parallel, but insulated, discourses.

Rationale for replication

Arguments for increasing the coverage and impact of programs are readily available. Practitioners, policy makers, researchers, and funding agencies would agree that there is sufficient knowledge and experience to address most of the serious problems facing children.[3] As so many children are still not reached, there is an obligation to extend, disseminate, or replicate this information so that more can take part. The assignment, therefore, is not so much to improve the "state-of-the-art", but rather to lift up the "state-of-practice".[4]

A related angle is provided by the assertion that it makes sense on pragmatic and economic grounds to replicate what has proven to be working rather than to reinvent the wheel. This argument is increasingly gaining ground with donors and policy makers alike. In an environment of shrinking resources for the social sector, foundations and governmental agencies are coming under increasing pressure to show "results". They are also accused of spending the bulk of their resources on innovation and project identification rather than on replication. It is suggested that replicating good practice is a cost-effective means of utilising scarce resources. The assertion is that money would be saved if project experience could just be transferred to other sites.[5] Consequently, funding and implementing organisations are under pressure to focus on bringing to scale existing programs rather than supporting yet more "experimental", "pilot", "innovative", "alternative", or "trial" projects.[6]

Recently, a more developmental rationale has been put forward.[7] The spreading of good practice is viewed not merely as trying to persuade others to mount identical programs, but rather as an opportunity for mutual learning and sharing of experience. A positive outcome of exchanging experience, according to this view, is that it allows networks of people and groups to develop. These can, in turn, grow into coalitions that can demand more political attention and appeal for larger allocations of means and also evolve into institutional vehicles for internal problem-solving. In practice, a combination of economic and developmental motives may well provide the justification for dissemination and scaling-up.

Strategies for increasing coverage

In many human development and research circles concerned with developing innovative and effective social programs, dissemination was rarely an issue for deliberate reflection at the start of a project. It was more or less assumed that once a pilot project had been successfully completed, replication would follow as a matter of course. At most, a report would be written and a set of recommendations formulated "*for further action*". This further action was then considered to be the task of others. As a rule, no information was provided on who the others were, or it was only provided in general terms such as "practitioners", the "government", or the "NGO community". Neither was it made clear how these others should go about spreading the good news.

In response to rising pressure to look beyond the pilot phase of a project and to assume active responsibility for following up on project outcomes, many donor agencies made the inclusion of dissemination a mandatory objective for providing funding. Even when formally stated as one of the objectives, project designers tended not to look beyond the boundaries of their present work and think about its wider implications. Many donor agencies which carry the pursuit of replication in their banner tend not to move beyond mere rhetoric. The majority do not provide long standing support for replication work, resulting in the creation of "white elephants" and dependency on external funding.[8]

In recent years there has been a renewed interest in applying the principles of knowledge transfer in social programs.[9] Donor agencies, governments and the international development community are all expressing a concern for making use of existing, well-tested experience. This has provided an impetus to documenting and broadcasting illustrative cases and there is now a steady flow of descriptions of commendable projects,

models, and of approaches "that work". This information about good programs is expected to assist others in developing their own work. Attempts have also been made to highlight the ingredients or key features that make for success and to provide practical guidelines and strategies for dissemination.[10]

The following distinct paths to replication may be distinguished in the social sector:[11]
Franchise approach: Also known as the "*cookie-cutter*" approach, it is closest to the private sector in its policy and practice. It assumes that there is a product - in this case a program - that can be replicated. The components of this prototype program and performance standards are largely inviolable. There is a central agency, usually the franchiser, which provides technical assistance, marketing, training and other services.

Mandated replication: This approach is usually, though not necessarily, sponsored by government and occurs when a parent body wants to disseminate a prototype program through the organisations under its jurisdiction. Mandated replication is always top-down and there is usually no element of choice involved.

Staged replication: This is the most structured approach to replication and takes place in three stages. The first is the pilot stage where the viability of the program concept is tested; followed by the demonstration stage where the program is implemented in a variety of sites. This stage is usually closely monitored and rigorously evaluated and successful demonstration is followed by replication. The analogy is often drawn with prototype testing and development in the private sector and the need for an independent replicating agency is often stressed.

Concept Replication: In this approach the focus is not on the universal and specific elements of the prototype program but rather on general components and principles which can be transported to other sites. Unlike the approaches mentioned earlier, strict adherence to the strategies and the model of the prototype are not required and success is measured in terms of adaptation and sensitivity to each unique local context. There is also no accountability for how components are transferred and used at each local site.

Spontaneous or Endogenous Replication: The essential difference here is that the demand for information comes from below. It is need based and is characterised by spontaneous and informal contacts between like-minded individuals. Additionally, the communication flow is not one-way - from recognized model to recipient - but rather a two-way process of convergence where participants "create and share information".

In reality, dissemination efforts usually combine features of the approaches listed above. However, for the sake of clarity, two contrasting approaches are identified in this paper. The first will be called universalist - broadly speaking, proponents of this view share a belief in universal principles which can be applicable to a very wide band of practices and situations. The dissemination effort is supply-determined. The second approach is termed contextual - the emphasis here is on local practice, local initiative, spontaneity, mutual learning and problem solving. The dissemination effort is demand-driven. While both approaches are acceptable in principle, emphasising one or the other would determine the choice and adoption of sharply contrasting strategies. There are sufficient commonalities in the first three forms of replication to warrant grouping them under the universalist label.

whilst the fourth and fifth could be termed contextualist. It may be worth noting here that advocates of the universalist and contextual approaches largely debate their separate viewpoints in insulated groups and there is little evidence of learning from each other.

Universalist approach: an appraisal

The universalist viewpoint appears to be gaining ground as a potential strategy for extending the scale of effective programs in the social sector.[12] Two broad trends are discernible in the literature. First, while paying lip service to the validity and importance of concept replication, a strong preference is expressed for developing a more planned, structured and controlled approach to disseminating good practice. This is reflected in a call for adherence to standards and principles; for protecting the identity of the program that is being replicated; and for charting out admissions requirements for selecting local sites. There is a move towards giving this controlling function to an intermediary organization which acts as the replicating agent and has "final accountability for program performance". A need has also been expressed for a national agency which can develop and promote replication strategies and speak with an authoritative voice on the subject.[13]

A second and related move is towards applying theories and practices developed in the private sector to replication efforts in the non-profit sector.[14] According to RPS (1994:ii), replication in the social sector "... *is entrepreneurial, market-driven ... In short it appears to be analogous to our market economy*". This conclusion is based on their finding that the most successful replication does not take place as a consequence of deliberate policy but is the result of a private entrepreneurial effort, very similar to starting a new business. Thus, in the social sector also, replication efforts would require a "champion" or "program entrepreneur" who has the charismatic and leadership qualities required to design program strategies, promote its achievements and secure long-term funding.[15] Once conceived, the program would need to be "marketed" and "promoted" in order to raise its public profile and increase its ability to compete for scarce funding. Concern is expressed at the lack of "incentives", in sharp contrast to the private sector, which would be required to sustain commitment to the program. Finally, there would be a need for protecting the program prototype from being cloned or expropriated without due acknowledgement and payment. It is suggested that in order to avoid loss of revenue, to protect the reputation of the program, and prevent misuse of key concepts and strategies, the social sector would in future need to enforce copyrights and patents and levy licensing fees.

In short, in order to be successful, replication strategies should look to the business sector for inspiration, in particular to the field of business franchising.[16] It is suggested that the participants and donors can be assured of certain quality standards in large-scale franchised programs. The licensing agreements to carry out the program usually entail an adherence to fixed standards of effectiveness. Training, upgrading and inspection are the responsibility of the franchising agent and there is the stipulation that the licence can be removed if the subcontractor fails to meet certain standards. Funding agencies are more inclined to invest in the expansion of such programs.

Despite earlier critiques of the universalist approach from various disciplines, it is once again in the foreground of social action, but this time taking its cue from the private sector. Several factors could be held responsible for this trend. The recent resource crunch has implied a move away from government funding of social programs and a

corresponding increase in the importance of the voluntary or non-profit sector for the delivery of such programs. Governments have increasingly incorporated principles of corporate philosophy with respect to the use of its own resources and also for the disbursal of funds to the voluntary sector. At the same time, social problems have not decreased and there is an urgency in the search for successful prototypes. Given this climate, and the parallel rise in corporate philanthropy, techniques developed in the private sector have percolated into the world of social programs. While it is undeniable that there is a real and immediate need to search for solutions that reach more people, it remains necessary to consider the appropriateness of these techniques and to anticipate and examine their weaknesses.

First, replication is seen as the culmination of a uni-linear unfolding of discrete activities starting with the pilot and the demonstration stages. Agencies' annual reports, conference discussion papers and research and evaluation reports present innumerable examples of variations and elaborations of these stages. But the existence of these stages and their sequential order is hardly challenged. A close look at practice reveals that they are often not clearly distinguishable and they, or their elements, may exist simultaneously. Projects never work in total isolation, they have radiation effects and they respond to environmental influences from the onset. This is especially the case when project staff belong to varied networks and are in constant communication with others.

Second, this approach looks on program replication as an activity to be carried out largely by the sponsor or initiator of the original project. These initiators are generally governmental or semi-state agencies and private or non-governmental organisations as well as so-called "pioneers", "champions", or "charismatic leaders" belonging to these organisations. The designation of the sponsor as the main directing and initiating actor has far-reaching consequences. It immediately builds into the work a "source bias" reflecting the interests, style and values of the sponsor.[17] Going-to-scale becomes a centralised, top-down process with the major decisions made at "headquarters".[18]

Third, there are dangers inherent in transferring strategies developed in the business sector to improve replication practice in the social sector. There can be vast differences in objectives, guiding philosophy, target groups, values and mission. Principles and practices that have been developed to maximise profit might not be applicable, beyond a point, to agencies working for the benefit of disadvantaged sections of society. For example, notions of staff ownership and commitment, and the need for transparency and participatory decision-making are viewed very differently in the two sectors.[19] It would be difficult to juggle the need for local participation, ownership and responsiveness to contextual variables - crucial elements in social programs - with the requirement of standardisation which are central to the franchise approach. It is interesting to note that even franchised operations are increasingly allowing for local input and creativity and imposing standardisation only where necessary.

The World Organization of the Scout Movement/World Scout Foundation aptly illustrates this move towards increased contextualisation in the social sector.[20] World-wide the organization counts over 32 million members, boys and girls. Scout groups differ widely from country to country, and within countries, from place to place. In Indonesia, Scouting is compulsory, and every school-going boy has to join; in Yemen it is very much a an

elitist activity; and in the USA, scouting is a strong commercialised movement.[21] The activities carried out by scouts cover the range from complete leisure to fully-committed social action and the mechanisms that keep the movement together are elastic. At present these consist of rituals, external paraphernalia and a well-run organisational structure. Local groups take care of their own funding, and contribute to the running costs of regional and international headquarters.[22]

Fourth, there is yet another danger to "*cookie-cutter*" replications which remain faithful in their form and content to the original "model" program. They may succeed and even be locally supported, especially if they appeal to a well-resourced leadership, but do they work to the benefit of their target group? Sustaining such a model may even become counterproductive as it could absorb all available resources and discourage the promotion of other, more appropriate models. Everything else becomes less attractive, not to be emulated. For example, it is a familiar sight in derelict or deprived areas to see "first class" day care centres, pre-schools or even well-resourced mother groups that in all respects resemble the facilities available in better endowed places. These exact replicas have often been established by benefactors who, in tandem with local leaders, want "the best of the best" for children. They are usually the show pieces reserved for visitors and the media but they may reach only a fraction of the children, families or mothers, living in the neighbourhood. It is also likely that the services offered would be appropriated by the least disadvantaged children. For financial and psychological reasons, the existence of such a service could foreclose any other form of assistance to deprived families and children in the area.

Finally, in the current trend towards "planned" replication, there is an undue stress on technical and organisational aspects at the cost of human and social aspects. Social reality is inherently complex and does not submit in a predictable manner to externally imposed interventions, no matter how well planned or technically sound they may be. At the heart of all social processes are people and they are also the intended beneficiaries of social programs. Unless the human aspect is given due consideration in the design and dissemination of programs, the effort is likely to fail. According to Cernea (1991:7) "the neglect of social dimensions in intervention-caused development always takes revenge on the outcome".[23] In the world of development practice and literature, there is an increasing awareness of the need to 'put people first' in the planning of intervention programs (Cernea 1991; Chambers, 1994; Korten & Klauss, 1990). A change is called for in the conventional approach to planning, which is dominated by technical factors and administrative details. The rationale for this change is sought not just on ethical and humanitarian grounds but is rooted in the belief that this is essential for assuring the effectiveness of programs.

Contextualist approach: an appraisal

The contextualist approach recognises the uniqueness of each particular setting, thus precluding the wholesale cloning of models and practices from one context to another. Primacy is given to addressing local needs, adapting to local environments and acknowledging the validity of local knowledge. The relationship between the giver and receiver is viewed as equal and non-hierarchical and each exchange is a potential opportunity for mutual learning. The very term "dissemination" is seen to carry the connotation of a dependent or passive receiver; as are the words "target audience",

"consumers" and "takers". Instead, notions of "partnership" and "convergence" should govern all exchanges.

In a parallel discussion on the merits and demerits of centralised versus decentralised diffusion, Rogers and Marcus (1983) note that a centralised approach is preferred only when highly-technical expertise is required, otherwise a decentralised approach is preferred. Contrasting the two strategies they observe that decentralisation invites local control, stimulates staying power, promotes peer-to-peer diffusion and horizontal networks, encourages local experimentation by local non-experts, is problem centred and demand-driven and has a higher degree of adaptation. Centralisation is dependent on highly-trained experts, is top down, draws on research for innovation, manifests a low degree of adaptation and is supply driven.

It is obvious that the contextual approach is more suited to the transfer of components and principles and not to the actual replication of a project or program. The key words frequently used are: indirect, dispersed, inadvertent, spontaneous, less measurable, and less geographically bounded (Chambers, 1993). Not surprisingly, no framework or blue-print is prescribed for implementing this strategy and there is room for using indirect means for achieving wider impact and coverage. Thus, activities such as lobbying, influencing policy, advocacy, training and networking are deemed to have equal, if not more, significant results than direct dissemination.[24] Each individual situation should determine the choice of strategy to be followed; in certain cases a combination of approaches may well be the most feasible course of action. While "expansion" and "addition" are seen as obvious means of increasing impact and coverage, it is felt that indirect means of replication should be given due recognition as they can often have superior results. Advocates of the contextual school rarely approach dissemination and replication strategies in isolation but place them in the wider framework of development theory and discussions on NGO management, impact and efficiency.[25]

There are several merits to the contextualist approach - more particularly, its sensitivity to the local level, the importance that is given to local knowledge and to need-driven demands for information, and its acceptance of the relevance of direct and indirect means of increasing impact - to make it an attractive component of any replication strategy. It is empowering, ensures local control and encourages self-generated learning. At first glance, it would also appear to contain all the elements required for developing an appropriate strategy for replicating policies, programs and practices - the starting point of this paper. A closer look at this approach in practice reveals some weaknesses.

First, notwithstanding its strengths, critics of the contextualist approach would deny it the label of a strategy since there are few rules governing its implementation. The replication effort is informal and dispersed and there are few well-defined criteria for evaluating its success. The premise of the uniqueness of each situation can sometimes be taken to an extreme. If all commonality is denied, room can be left open for unnecessary re-inventions of the wheel, with each local agency expending time and resources to find new solutions to problems that are not unique. It is not rare for small organisations to become self-serving and inward-looking with little or no contact with other like-minded actors. This precludes them from coalition-building and from joining forces in the interests of a common cause. A major avenue for increasing the impact of the work of the local sector could then be lost.

Second, the objective of increasing impact and coverage is also not served well if there is an undue focus on processes at the cost of outcomes. Some proponents of this approach would go so far as to reject the notion of planned, step-wise change, especially in community-based work. According to Smale (1993:16), "most people need to reinvent their own wheels and want to use them in their own way". Consequently, there cannot be a blue-print for community-based practice as "there are no destinations, only journeys". However, it would be difficult to deny that journeys could and should be undertaken with some sense of destination in mind. If the aim of social programs is to mitigate the effects of social disadvantage, the interests of the target group will not be served well by a strategy which leaves so much to chance.

Third, an element of wishful thinking and romanticization can be detected in the notion of decentralisation of diffusion efforts. It is necessary to bear in mind the critiques developed in the discourse on decentralisation where devolution of authority is sharply distinguished from democratisation. It is emphasised that the focus should not be just on shifting the responsibility for financial allocations and decision-making but equally on understanding the nature of local power structures and political processes which get "empowered" as a result of decentralisation. Writing more than a decade ago about the "myth of decentralisation", Bryant and White (1982) warn that it can invite corruption, internecine warfare and take-over by local elites.[28]

Finally, it is important to ask the question: who assesses local needs and how are they legitimised? All too often, this is done by an outside agent - the "animator" - or by the representative of a donor agency. Needs, priorities and areas for intervention are often defined on the basis of a short exposure or a superficial knowledge of the field. Local hierarchies, power structures and disagreements may not be reflected in the message that is taken back. For example, undue emphasis may be given to the voices of the most vocal and visible children or their parents, who may not be the most vulnerable and marginalized.

Pointers for program replication

The universalist and contextualist approaches both have their relative merits and in real situations they can often be combined, bringing out their individual strengths and mitigating their weaknesses. No matter what approach is used, accumulated experience - in research, policy and practice - shows that replication is a complicated, costly and time-consuming process. There are no easy solutions to it and no short cuts. However, it is useful to look at the various trends in programs for children, policy and practice that offer promise - including those found in development experience - and also to explore the long research tradition in related social science disciplines where parallel discussions are held on the subjects of knowledge transfer and use. The integration of inputs from these distinct field of practice and research yield some considerations that need to be kept in mind when discussing replication in the social sector.

Commonality versus specificity of children's issues

In most countries of the world children are faced with many problems that are strikingly similar. Although opportunities for positive development differ from country to country, the obstacles and risks threatening their well being have elements of commonality. A listing of the most pressing issues facing youth would not differ dramatically from one

country to the next. Korten (1990), writing about wider development issues, mentions by way of illustration over twenty "problems", that do not recognize North-South or East-West distinctions. Some of the needs that are increasingly shared in common are:

- reducing chronic unemployment;
- controlling drug trafficking and abuse;
- managing population growth and distribution;
- reducing teenage pregnancy;
- providing housing for the homeless;
- making credit available for micro-economic activities;
- reducing hunger, illiteracy and infant mortality among difficult to reach populations;
- treating AIDS victims and controlling the spread of the disease;
- meeting the needs for bilingual education;
- facilitating reconciliation among racial, religious and ethnic groups;
- resettling refugees;
- ensuring the preservation of human rights; and
- increasing citizen awareness of global development issues.

This list could, especially with the situation of young children in mind, readily be extended to include the following tasks:

- combatting physical and child abuse;
- supporting young families;
- reducing hazardous environments;
- expanding and improving day care facilities; and
- promoting the rights of the child.

The implicit global risk factors have a direct bearing on the well-being of children, particularly those who already live under stress caused by poverty, discrimination, or disabilities. Many children, especially those living in the poor regions of the world, have become the "victims of a cruel paradox". As the world community succeeds in keeping more children alive, more of them grow up physically and mentally truncated (Bendahmane, 1994). Youth in the richer countries are also sensitive to these risk factors. A recent study reveals that 15-30% of children in the OECD countries could be considered "at risk" for the same reasons (Evans 1995).

Further, the causes of these problems, and their manifestations, do not run parallel to each other, but are closely interdependent. Being commonly rooted, these problems often appear in clusters. Studies from the United States confirm that risk behaviours are interrelated in children and youth: nearly 50% of American youth are involved in two or more of the four categories of risk behaviours that have been identified as: drug and alcohol use and abuse; unsafe sex, teenage pregnancy, and teenage parenting; school failure, underachievement and dropout, and; delinquency, crime and violence (Lerner, 1995).

In recognising the commonalities of children's issues, the underlying specificity's of each local situation should not be ignored. Seeking common solutions to shared problems could well imply a negation of underlying contextual differences and a stifling of need-based local action. Care needs to be exercised not to impose "universal" solutions to problems which are intrinsically local and to avoid co-opting local initiatives into donor-determined,

homogenised approaches. In fact, a sensitive balance has to be struck between accepting what is universal or global while recognising and protecting what is valuable at the local level. This issue strikes at the very heart of the discussions on how to disseminate and replicate policies and practices across cultures and borders.

What makes programs work?

A first step to understanding why programs work is to uncover the principles and processes underlying "good practice". Most reviews of successful programs are mainly descriptive in nature; they seldom go further than offering evidence that the project has a positive effect on children and should, therefore, be supported or emulated. Analytical studies which reveal why programs work, under what conditions, and how are rare. Without this understanding, the disseminating of projects, or of their elements, could degenerate into a form of blind cloning or become a matter of intuition.

A number of principles have already been referred to in the text as they appear to be essential to most successful programs. They include empowerment of users, recognition of cultural diversity and local needs, promotion of holistic development, and parental involvement. However, mechanical adherence to these principles will not automatically lead to positive development of children and youth; their meaning and function should be continually analyzed. For example, a deeper understanding of the processes underlying parental involvement can be obtained by asking questions such as: how does parental involvement work; what mediating role do parents play between the child and the environment; what factors affect this mediating role of the parents; and, do similar social conditions affect fathers and mothers, in what ways and why?

It is important to bear in mind that knowledge and practice are not stable - they have to be reviewed all the time. Questions have to be posed continually and in each different context as the answers will vary accordingly. Understanding the issues underlying wider principles is, therefore, necessary to counter the mechanical application of outdated practice. It will also ensure that programs and policies are not static but remain responsive to the changing needs of children.

Giving validity to all knowledge

A review of critical writings in the field of knowledge use and transfer reveal important guidelines for replication in the social sector. These are of particular relevance in situations where government departments or large funding agencies take the lead in dissemination efforts.[27] The most fundamental conclusion of these critiques is that knowledge is not objective or value-free; it is identified with the groups that create it and it serves to further their interests while disregarding those of others. In order to ensure that dissemination does not become a way of exerting power and control over small, local organisations, care should be taken not to treat "knowledge users" as empty receptacles with no mechanisms for their own knowledge creation. This requires giving validity to all kinds of knowledge - be it research or practitioner knowledge. Similarly, in order to be truly effective, knowledge should not be imposed from outside but should be owned or internalised by users. Ideally, two-way information sharing, rather than knowledge flowing from a single source, would be one way to avoid this situation. At the practical level, it would be more effective to present users with a range of program and policy options rather than to

promote one particular prototype. This would allow them to make comparisons and to select and combine elements to suit their particular environment.

Networking as a tool for dissemination

Outcome-oriented networking of networks could be yet another way of disseminating good practice. The participants should belong to vertically and horizontally linked structures, connecting public and private organisations. These networks should be multi-nodal and should comprise autonomous subsystems. There should not be a tightly-structured chain of command or communication. The participants should have the capacity to act and learn without being forced to do so and they should have the potential for voluntary and collective action. Most importantly, they can form coalitions of smaller NGOs, or even governmental organisations, who can act together to make an impact.

Networking also has its drawbacks: network meetings are not low-cost. They can easily degenerate into talking shops, or turn into elite groups, excluding others and monopolising the debate. These unproductive dynamics can be avoided by encouraging the participation of groups or sub-networks working close to children. This can be done by identifying specific needs and problems among the network partners; by setting goal-oriented agendas; and by facilitating and monitoring progress. Sustained, effective and locally rooted dissemination is most likely to take place through outcome-directed networking. Target setting is required. Replication through networking is not likely to evolve spontaneously or from the bottom up; guidance and direction by a centralised force is usually needed, not only to initiate but also to supervise and sustain the process. Traditionally, government agencies and grant-making organisations assume this role. Some of the problems associated with this could be avoided if NGO coalitions were also to take on these functions.

Concluding observations

This contribution has not sought to produce a list of straightforward recommendations. These abound in the literature emanating from the non-profit sector and display a general tendency to reduce the many dimensions of this issue into a set of how-to-do guidelines. But it is only when the processes of going to scale are appreciated in their full complexity that meaningful policy can be drawn up. The search for simplicity has been a main stumbling block in the formulation of this policy. Some of the complexities underlying the question of program replication have been touched upon in this text.

The progress of replication efforts is often measured in terms of criteria such as the effect on the participants, the number of children reached; the spread of project sites over the country, region or world; the volume of services extended, of the institution or of its staff. When these indicators meet expectations, the program is judged to be successful. Seldom, if ever, are advances gauged against the needs of all children in a given country or region. Thus, while an organization is expanding its exemplary programs the impact on the total population of children may remain insignificant. It is hard to judge the relevance of dissemination programs which are carried out without a clear understanding of the total picture. There is a need for a system that would monitor the situation of children. At the most basic level, such a monitor would gather data on children, their needs, what programs are offered for them, how many participate and who and how many are left out, or how many require special attention.[28] Additionally, the monitor would feed back information and demonstrate the effectiveness of dissemination programs to all

participants. A self-monitoring system used by the participants would be an important force in increasing the outreach of services.

The expansion of program coverage is often the outcome of an intricate interplay between donor and recipient agencies. The relationship between donors and recipients is, by definition, unequal. Barring rare occasions where popular NGOs are courted by the entire donor community, recipients are dependent for their income and livelihood on donors and will, in varying degrees, cut their cloth according to the donors' whims and wishes. In spite of the often encountered expressions of "genuine partnership" and "critical dialogue" it is the donor who, in the ultimate analysis, calls the shots.[29] As most donors and development agencies are identified with the West, there is also the danger of imposing models and practices developed in the West at the cost of existing and effective local customs and approaches. Dissemination efforts spearheaded by prestigious persons such as first ladies, celebrities or royalty should also be looked at with circumspection, particularly, when they take a guiding role with respect to the direction and content of the program.[30] Throughout this text, various pointers have been suggested on how to professionalize the relationship between donor and recipient. Early involvement in project design and planning by all stake-holders, working through transparent networks, NGO capacity building, and evaluations are some of the most prominent tools to this end. The philosophical underpinnings of the code of conduct for donors have been worked out extensively by Pantin (1979, 1983), who summarizes this philosophy in two words: respectful listening.

A main argument running through this paper is that effective and sustainable programs reaching out to large numbers of children and youth are few and far between and take a long time to establish. In 1975, a survey showed that after a decade of intensive debates and federal, state and municipal involvement (Goldman and Dotson, 1975) life for youth in the inner cities of North America had only worsened. Now, twenty years later, the situation is not better and has, in fact, deteriorated further.[31] This has happened, or has been allowed to happen, against the back cloth of efforts to expand programs that "work"; the availability of tried and tested program and policy scenarios; and the existence of vast skills and knowledge on how to implement these. The situation of children in other countries is often not much different.[32] Given this track record, it behoves politicians, researchers, donors and policy makers to adopt an attitude of profound modesty, or even wariness, about their ideas regarding children and about any future scenarios they set in motion. It may well be that an informed uncertainty proves to be a better compass to go by in the debate on replication than a set of over-confident, but ill-informed recommendations.

Notes

1 This paper draws on an earlier study '*Replicating Youth Programs*', conducted for the International Youth Foundation.

2 See, for example, Glaser, Abelson and Garrison (1983) and Rogers (1976).

3 See, for example, Myers (1992), NASW (1993), Pittman (1995), Schorr (1989). The First Lady of USA, Hillary Rodham Clinton, (1995), also contends that "we do not lack the information, but rather the will to do what is best".

4 See, for example, Myers (1992), NASW (1993), Schorr (1989). The International Youth Foundation (IYF), whose explicit mandate it is to "replicate good practice", operates YOUTHNET. This is a data bank containing a growing number of descriptions of international "exemplary" projects.

5 There is little evidence in the literature, however, to suggest that planned or staged replication of project prototypes is an any way less costly than starting a new program. On the contrary, most research shows that it can be an expensive process requiring vast human and financial resources. Bieman and Tomlinson (1992) note the high costs involved in any exchange of practices and ideas within a North-South context.

6 This trend is particularly strong in the United States as witnessed by the fact that many foundations have taken up "going-to-scale" as a major topic in their programming. See for example, Birman and Kaufman (1991); Council of Foundations (1993); Mott Foundation (1990); Paisley et al (1983); and International Youth Foundation (1991-1995).

7 See, for example, Cernea (1991), Chambers (1993), Edwards and Hulme (1992) and Pottier (1993).

8 There is also a discernible tendency in donor agencies for new staff to undertake new initiatives in order to make their mark, while old staff often succumb to "donor fatigue" and tend to respond much more enthusiastically to innovations than to variations of the same.

9 See, *inter alia*, Backer (1993); Chambers (1993); Conservation Company (1993); Conservation Company and Public/Private Ventures (1993); Dichter (1989); De Lone (1995); Edwards and Hulme (1992); Mott Foundation (1990); NASW (1993); Public/Private Ventures (1990); Replication and Program Services (1994); Rothman and Edwin (1994).

10 With respect to the area of children and youth, a review of in-depth as well as meta-studies shows that the majority of effective programs meet a certain combination of criteria. Briefly, they focus on children; promote positive growth; are preventative; allow for optimal participation by the children, parents and communities; are contextual and respond to local needs; have a positive bias towards vulnerable groups, especially poor children and girls; are horizontally and vertically embedded in organisational structures; and are low-cost. They are also well managed; conduct regular evaluations and offer training opportunities to their staff (Grant 1990; International Initiative 1991a,b; International Youth Foundation 1991-5; Van Oudenhoven 1989).

11 The first four paths to replication have been identified by RPS (1994) on the basis of their survey of US practice. RPS also provide a listing and descriptions of US-based youth programs which fall into each of the four categories.

12 Proponents of this approach are: Backer (1992a,b); Charles Stewart Mott Foundation (1990); Conservation Company (1993); De Lone (1990); Public/Private Ventures (1990); Replication and Program Services (1994).

13 Recognising the importance of such an agent, private organisations in USA have established the specialized inter-agency service: Replication and Program Services, Inc. (RPS). Based in Philadelphia, this new office provides support to foundations and private voluntary organisations in disseminating their work.

14 See Archie 1993; Backer 1992; Mannes and Meilleur 1989; Oster 1992; RPS 1994.

15 The role of the "champion" is seen by many as crucial for dissemination efforts. The argument runs that somebody is needed who believes in disseminating program outcomes, who is committed to it, is internally motivated, who can push and move things, and has the skills, endurance and personality to carry on and to convince others to follow. Dr Walter Barker, the initiator of the Irish Community Mothers Programme on which MIM is modelled, is such a champion. However, as these champions are not always easily found and do not live forever, it is often recommended that an external, professional "replication agent" be appointed to guide the dissemination. What they would lack in personal qualities would be made up by their expertise, professional interest, and external incentives.

16 The franchising of programs, products, names, and logos is common practice in the field of social programs in the USA. More than half of the top one hundred charitable non-profits, e.g. American Red Cross, YMCA, and Scouting groups are franchising organisations (Oster 1992). They transfer to franchisees the exclusive right to

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use their "trademark" or sell certain products, usually in a particular territory, for which they receive payment. The franchiser provides assistance and exerts control over aspects of the operation. Profits, losses and liabilities are borne locally. Similar practices are now becoming common in other countries as well.

17 According to Rogers (1976) research and evaluation studies of replication have also been heavily "source biased" as they have mainly been commissioned by sponsors.

18 What, for example, is the **commitment** needed to sell a McDonald hamburger?

19 It is not surprising that most of the deliberations on replication take place at the behest of organisations which wield power to implement decisions.

20 See various information leaflets from Scouting Nederland, WOSM/WSF Geneva and Van Vliet (1995).

21 The many local and national differences became manifest, almost to the point of mutual non-recognition, at the triennial Jamboree in The Netherlands in 1995. The Japanese scouts were appalled to see Dutch scouts kissing each other. The Dutch were, in turn, stunned by the military look of the Japanese, while many Muslim scouts were not allowed to have any companionship between boys and girls whatsoever. Uniforms varied equally widely.

22 The Scout movement cannot be seen as specifically concerned about **disadvantaged** youth. Franchised organisations for youth at risk do exist and operate along the same principles. In the main, the emphasis is then on the protection of the use of the name of the organization, educational materials, and training/membership requirements. Funding comes from external resources as the participants cannot generate these.

23 A re-evaluation of 25 World Bank financed projects shows that 13 of these were unsustainable, not for financial reasons, but because socio-cultural factors had been neglected at the stage of project formulation and implementation: (Cernea 1991).

24 See Cernea (1991); Chambers (1993); Clark (1991); Edwards and Hulme (1992); Korten and Klaus (1990).

25 A recent publication, exploring the different ways in which NGOs should increase their impact lists three strategies for dissemination: **additive** -implying an increase in the size of the program or organization; **multiplicative** - where impact is achieved through deliberate influence, networking, policy and legal reform, or training; and **diffusive** - where spread is informal and spontaneous. No preference is expressed for any one strategy as each would be effective in a different circumstance and no clear-cut criteria are provided for implementing the various strategies (Edwards and Hulme 1992).

26 Dillinger (1994), overseeing the international scene and writing for The World Bank, states that the objectives of decentralisation are only tangentially related to administrative performance. He believes that governments are not genuinely interested in delegating responsibilities aimed at improving service delivery. At best they agree to a disorderly and reluctant series of concessions, primarily to maintain political stability. Recent developments in inter-sectorial networking may merge the advantages of both centralised and decentralised strategies.

27 See Huberman (1994-95); Nilsson and Sunesson (1993; Watkins 1994-95).

28 See Van Tilborg and Riemersma (1995) and Zusovsky (1994) for detailed descriptions of the role of monitors.

29 See Wazir and Van Oudenhoven (1997).

30 The involvement of well-know people in program promotion has become a regular feature on the development scene. Their use is obvious: they help to attract attention, open up doors and rally people around a good cause. It is argued here, however, that involvement should be restricted to promotion and not to guiding the direction and content of programs.

31 Kozal (1995), writing about children in urban ghettos reports that child poverty in USA has reached its highest level since 1964. "People have become tired of shouting", he notes.

32 Evidently, much has gone wrong and several attempts have been made to reflect on these poor outcomes and on what could be learnt from the past. See, for example, Grant (1989) and Klein and Gwaltney (1991). The implicit suggestion in their work is that if certain missing areas were given proper attention, things would go better. It is not certain if this optimism, which is expressed at many fora, is warranted.

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12. ISSUES OF PROGRAM DESIGN AND IMPLEMENTATION

Bert Prinsen

In this book we were able to benefit from the experiences and results of programs from five different countries. We have looked at these programs from various perspectives. It gives us confidence to work towards further development and implementation of community based support programs. The expectation is that these programs have a sound and healthy future.

Implementing this kind of program requires different strategies:

- to enhance the quality of care and the development of quality assurance variables for the programs themselves;
- to execute evaluative research which is needed to be able to develop effective programs;
- to continue the selling of these kinds of programs to policy makers, practitioners and the public at large.

These are some of the main issues of development and implementation for the next few years, bringing the results of program development to a widespread innovation in the field of youth development and early child care. One question comes to our mind: "What are the present perspectives of developing and implementing such programs in countries in the Western world?" To find possible answers to this question is the main thrust of our contribution.

Development and implementation

The development of practicable (inter)national programs in the field of health care and pedagogical support of parents of young children is a long-term matter. Ever since the first innovation theories were formulated (Havelock, 1971; Rogers and Shoemaker, 1971) we have known that the development and dissemination of such new programs takes place according to predictable patterns and a well-known set of procedures. On the other side the actual course of innovation can be very freakish and unpredictable in nature. This is determined by social and political circumstances. The experiences with community based support programs in various stages of development and use in the five countries described in this book confirm this pattern. The framework, theory and the design of the program have been sufficiently developed and it appears to be an intrinsically and systematically useful and feasible program. Application variations and use are increasing, but as yet the programs have not been widely disseminated. Implementation is a difficult job. This is due mainly to the fact that in community based support programs two different worlds collide. Worlds with different attitudes, values and norms: Health care and welfare work. In addition we are also dealing with a combination of two types of programs: family support and health promotion. There is ample cause for closer inspection of the main issues that

determine the development and implementation chances of these programs. We will discuss respectively:

- the different roles of the mothers and professionals;
- development and designing of community based support programs;
- the mixture of family support and health promotion;
- research for developing programs;
- cues necessary for innovative action;
- different perspectives of implementation of the programs.

The different roles of the mothers and professionals

In chapter 2 of this book Carolina Kleinjan on behalf of the visiting mothers of Kruiswerk Gezinszorg Breda explains the role of visiting mothers as volunteers in the Dutch program. An Irish or English mother might very easily have presented as inspiring and realistic a picture of the participant's view of the program. The mothers - the volunteers - are the core of a community based support program. This does not only apply to the actual carrying out of the program, but also to their involvement in the development of the program. After all if one wants to develop a program based on "*the ideologies of empowerment, emancipation, and solidarity*", one cannot do this without a decisive input on the part of the program's users. In a health care culture dominated by doctors and nurses this was not easy. It is vitally necessary to be seen to be credible and not just to pay lip service to the concept of empowerment. A program which has empowerment and solidarity of paramount at its core will, at the very least, have to meet these standards. The ultimate consequence being that the mothers design their own programs. In this, we share Barker's stance in chapter five where he advocates not only community based, but also community led support programs with professionals in a facilitating and supportive role.

When we look at the programs in various countries, we see in the course of the development a shift in the professional attitude towards the role of the mothers. As innovation continues, the development moves forward and the recognition for the role of the mothers increases. In this respect, the changes in nurses, doctors and social workers are perhaps more important than the changes in the mothers themselves. For the mothers, there is 'merely' activation of potential resources and abilities. The attitudinal change in professionals is much deeper and more fundamental. A community based program requires professionals to adopt a modest and background role and allow the mothers to play the lead, preferably from the very beginning. The professionals should allow themselves to be in the service of the mothers.

Photograph: Willem Mes

Development and designing

The role of the mothers and professionals is one aspect of the development of community based support programs which contributes to the potential success of this type of program. One question remains: What makes the designing of such programs potentially successful? As of yet, we can only speak of potential success, due to the lack of published studies on the programs effectiveness. There are favourable indications of effects on health and independence (Johnson, 1992; Maloney, 1995; Wolf, 1995; Clinton & Matthews-Taylor, 1997) but we still await an international comparative study.

However, even with this reservation the question remains: What makes the program practicable and successful? When we compare the programs, we are struck by a number of common characteristics. We mention five common characteristics in the program design: A holistic approach, peer group home visiting, social support and networking, sharing experimental and specialist knowledge and participation and emancipation of women.

A holistic approach

All the programs described take a more or less holistic view of man and life. Health and education, working and living, economic and social life are linked and are not seen as isolated in the program. Parents and mothers are faced with the entire and undivided care and education of their child. The development of their child is taking place in all imaginable areas: social, intellectual, material, emotional, physical. Action on the part of parents does not take place in isolation either, but occurs in more or less poor conditions, either with or without support of family and friends, with or without a job, income or social benefits. The mothers in the program are not just women with merely a 'mother's role'. In addition they have their own lives and experiences as a partner, as employee or unemployed person, as volunteer, friend, consumer or in any other capacity. They are being addressed as persons, as human beings with or without faults.
The holistic character is also expressed in the contents of the program, as we shall see in the next paragraph. There is an integration of socio-scientific and medical-scientific knowledge, a mixture of family support and health promotion.

Peer group home visiting

A second active ingredient of the program design is the quality of the program with the mothers acting both in their capacities as givers and receivers of information. The method of peer group education is opted for in combination with home visits. Mothers, themselves part of the target group, are also the carriers of the program's message, as can be seen from the examples in part two of this book. Brenda Molloy uses the term de-roling in this context i.e. no more working for people but rather working with people. In theory one could put forward the proposition that the more the program is carried out by the target group, the more its range and possibly its effectiveness will increase (Gepkens and Gunning-Schepers, 1994). This is supported by program evaluations in different countries. The high regard for the role of the mothers is particularly striking, probably helped by the program taking place in a familiar surroundings for the mothers. It is apparent that these mothers are seen as reliable and credible. "*This is really useful*", you can hear the mothers saying themselves.

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What these mothers do can be described as:

- *bringing knowledge within reach and making it understandable ;*
- *reflecting on experiences and placing them in a certain context;*
- *listening;*
- *being there, evoking proximity or intimacy;*
- *giving personal attention;*
- *helping other women to rediscover their self-esteem;*
- *helping other women to cope with problems, and sometimes solving them.*

Many of these qualities we find in other circumstances in family, friendship and relationships. But not everybody is in a position to avail of those. It is then marvellous to get help offerd from someone who is in similar circumstances. The method of peer group education and home visits is not unique to community based support programs. It is used in programs combating social exclusion, local public health promotion (Tenhaeff, Prinsen, et. al., 1994) and it is also used in the context of European employment programs.

Social support and networking

Social support plays an important role. This is recognized by mothers and health workers alike. It is also recognized that health and educational problems have a social component, both on an individual as on a group level. Support and networking is advocated and used on both levels in various ways:

1 There are three ways to express support as Hermanns states in chapter four of this book: Emotional, informational and instrumental support.
2 Mothers are being supported in forming networks themselves, making and maintaining contacts, and getting out of the house.
3 The health care workers cannot support and supervise the program without appealing to their network in the community in which they work. They also need the support of other professionals in creches, community work, child health care, or police in order to publicise, administer and carry out the program adequately.
4 They need their network also to recruit mothers for participating or working in the program.

Sharing experimental and specialist knowledge

The program places equal value on the knowledge that mothers have gained from their own experience with caring and parenting their children and on the specialist knowledge of the different professional disciplines involved. A possible explanation for the program's success with mothers lies in the balance of the appreciation of these sources of knowledge. In the program it is the experienced mother's task to get specialist knowledge across using her personal experiences. In a way she translates the information into ready made chunks which the inexperienced mother understand, can use and relate to in her life. In the eyes of the inexperienced mother she is seen as the expert, namely an expert of and with children of her own.

Personal experiences, both positive and negative, have hardly any educational effect at all if they are not placed in a broader context. One mother's experiences will be accepted by another if they are seen to be linked to generally accepted knowledge, for example on education and child care. They increase the problem solving ability by adding a new element to the experience.

The program provides the mothers with an opportunity to reflect on experiences and they explore alternative "approaches". Mothers state in this respect: "*I am learning to pause and think of what I'm doing and to think of what I want.*"

Participation and emancipation

The last but not least characteristic might be the active and decisive role that the inexperienced and experienced mothers themselves play in the program. Their activities lead to more participation, due to their advertising by word of mouth, and create a basis of trust for the program among the target groups. The ultimate result could be a feeling of "*it is a program of our own*". At the individual level such emancipation will result in the discovery of "*being able to do much more than I thought possible*". The result of this "empowerment" is people regaining control over their own lives. This discovery sometimes has the consequence that people will develop talents in other directions. They look at other possibilities and perhaps look for other roles. Women will seek jobs, start (further) education or engage in other voluntary work for the community.
In this perspective we may speak of emancipation effects of the program. These programs thus contribute, unintentionally, to the strategy of education and training as investment in health, advocated by the World Bank (1993).

A family support and health mixture

Community based support programs could perhaps owe their enthousiastic reception by the target group to the synthesis, that is created between the worlds of health and welfare, the world of the individual and his immediate surroundings, and between laymen and professionals. In the previous paragraph we discussed this on the basis of the holistic approach. But this synthesis goes further than that.

Community based support programs are stimulated and initiated from two professional standpoints. The program is encouraged because it is seen as a possible means of addressing socio-economically determined health differences through health protection and promotion for people living in underprivileged circumstances. It is also seen as a program towards the prevention of possible educational problems, the addressing of social issues in a neighbourhood and as an incentive to emancipatory development. The holistic approach in these programs has not only to do with the professional environment from which they are initiated, but also touches upon the programs' contents. Socio-scientific and health-scientific thought meet in these programs.
In the day-to-day reality of the mothers participating in the program, this provides a fruitful synthesis. We must understand that in the mothers' perception questions on education, care, health, growing, the child's development are side by side. These mothers do not make the same distinctions which empirical-analytical thought of science advocates. Rather, they link these separated worlds and ask for support "so that they can solve their own problems in their own way".

In other respect also, there has been a synthesis: principles of family support programs are being combined with the principles of health promotion. In an analytical sense Bronfenbrenner, Super and Harkness laid the foundation for such an intervention program in the model of 'linked ecologies for child development', which Hanrahan described in chapter one of this book (Bronfenbrenner, 1979; Super and Harkness, 1986). Further

theoretical in-depth treatment of the intervention model of community based support programs can be linked to this model. It opposes intervention programs based on a strictly medical-preventative model with its highly prescribing nature. The current programs are linked in with a combination of social embedding, social support and individual development as principles of change. As was stated before, it would be an exiting prospect using a similar conceptual framework in developing a theoretical model of community based support programs for children in need and their parents.

Research for developing programs

Evaluating community based support programs is difficult and many colleagues are struggling to find a research approach to fit the program. Koelen and Hanrahan (see chapter 10) give some building blocks for developing an adequate research method. Four issues seems to be involved:

1. The development of a program requires a development-oriented approach on the part of the research itself. Action research seems to be indicated. Initially the results of such research cannot reach beyond the feasibility of the program and identification of the active ingredients (Barker and Anderson, 1988; Wolf, 1995).
2. A process evaluation can be carried out quite easily, but it will not clarify the program's achievements, only its feasibility. This type of evaluation will facilitate go, no go decisions in the development phase of the program and at the beginning of the implementation phase. In addition, it provides an insight into the course, mode of operation and interaction of the program itself. It can be a pitfall to use such research as a standard to measure the effects of the program on the child or its mother.
3. A program in development can be evaluated, but a stage has not yet been reached where demonstrated effects can be produced. Standardisation is first required. Only then does research into community interventions appear with the same authority as that produced by randomised control trials (Sturmans, Nutbeam et. al., 1997).
4. If there is to be implementation at all levels, national and institutional policy and program execution, we will then be faced with the predictable question as to the proved effectiveness of a program. This means that great care must be taken in the correct timing of any proposed research, if the program is to develop properly. Standardisation is, however, only possible when action research and process evaluation have provided sufficient insight into the effectiveness and feasibility of the program. The discussion on the effectiveness of the HIPPY program in Israel and the Netherlands is one example of the "burden of proof" question which will arise when programs are being implemented on a national scale.

It is comforting to know that if effectiveness is demonstrated by means of 'stricter research standards, the possibilities for implementation increase. Ireland has a head start in this regard due to research by Johnson (et al, 1993).

Cues for action needed for innovations

New programs and therefore community based support programs also, need a 'cue for action' to provoke individual professionals to change. Analogous to the 'health belief model' to bring about an attitudinal and behavioural shift among doctors, nurses, information officials and policy makers, an actual and real cue is needed to initiate change. Innovation does not take place spontaneously.

Professionals do not change, as "*the health care manager says it is necessary*". They need a personal motive to believe in something as new as community based support programs. Such programs will gain a stronger innovation potential if they engenders a deep-rooted motivation. In the programs discussed in this book this 'cue for action' for professionals can be situated in:

- empowerment: Professionals discover and gain trust in people's own powers and abilities;
- professional impotence: the repeated experience of not being able to reach people, in particular in underprivileged circumstances, with prescribing behaviour as opposed to the introduction to the results of an activating attitude and behaviour;
- the communication gap: The inability on the part of professionals to transfer knowledge, information and skills to the public (the mothers);
- solidarity: The manifest need to provide support and care to the weakest members of society;
- program effects: The pedagogical, health and socio-economic effects of 'community based support programs';
- vision on man and science: Lifting the separation of the sciences; breaching the gap between the medico-scientific and the socio-scientific thinking and the effects of this separation for mothers and children.

Professionals therefore can derive their personal motivation for co-operation in the program from various elements. And yet the program hardly gets away from the level of the individual professional, who "*believes in the role of community mothers*". More is required to progress from programs based on 'the beliefs of individuals' to locally, nationally and internationally established programs.

"*Think global, act local*" is an often heard expression in circles of the WHO and other international health organisations (Evers et.al., 1990). It expresses very well the two simultaneous and interacting, yet very different strategies which are necessary in order to improve people's health and quality of life on a wider scale. Van Oudenhoven and Wazir dealt with this extensively in chapter 11 on strategies for the increasing coverage of programs for children.

What else is needed, in addition to proof of effectiveness and sufficient motives for professionals, in order to improve the dissemination and quality of programs to such an extent that general acceptance is coming within reach? The experiences in Nashville, the different locations in Ireland, Wales and the Netherlands all teach us everything must be done at three levels: a local focal point, the community at large, and nationally. Let us examine the different levels at which improvements in dissemination of information and the quality of life can be implemented: The decisive link of the mothers' world and the professionals.

1 The participating community needs a focal point. The empowering attitude and the pro-activating behaviour of nurses and doctors are according to Barker and others decisive for a chance of success. In the local community the program is being given a human face, resulting in the mothers feeling that the program is theirs.

2 On a community level we find the specified applications of the programs each with their specific program conditions and management. The organization is locally embedded in the community and within this representatives of the target groups are given a voice. Local nurses or social workers take care of the continuous assessment of

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the program to ensure quality of care. On this level continuous adjustment is necessary all the time. Re-inventing the wheel is not necessary, for it is quite possible conceptually to transfer, implement and disseminate community based support programs but utilisation and adaptation according to local needs and circumstances will always be necessary.

3 On the national level program-concepts can be compared, ideology and paradigms can be analyzed, and implementation strategies utilised. The national program strategy can help to ensure continuity of funding.

Perspectives of implementation

The availability of a potentially successful program is not enough to implement a community based support program on a larger scale. This will take much more. Young parents should be made aware of the possibilities of participating in the program when and if needed. Individual health care workers need to foster a public-oriented attitude and the management structures of community nursing services or welfare organisations need to examine the advantages of the program in terms of the number of parents from the different target groups reached, spin-off effects in relation of positive public image towards their organization and unit costs.

Local circumstances are seldom ideal for an undisturbed start of the program. Funding is often subject to freakish patterns. Sandison and Sheridan describe in their chapters that this is an ongoing worry unless one is able to create a solid foundation within the organization or in politics. Community based support programs are not spectacular headline grabbing programs giving quick results and it can often take ten years before substantial effects are shown (Olds et al, 1993).

It will thus continue to take a considerable effort on the part of the mothers and professionals to place these programs on the political agenda of policy makers and practitioners. A more general restriction is that these programs are suffering from the limited insight into the costs of prevention. There is an enormous need for evaluative research and proof of effectiveness on health determinants, costs, education attainment and other social variables as a result of these programs. These restrictions however, need not be an obstacle to an efficient dissemination of innovative community based support programs. Chances for implementation increase as more successful activities within the programs are identified and some hard evidence is published.

In conclusion

Implementing community based support programs is possible, but will have to be nurtured in coming years with special attention given to:

- quality improvement of program development in strengthening the synthesis of family support programs and health promotion;
- stimulating participation of the target groups;
- marketing strategies which are well constructed and adequately managed and focused on policy makers, health care workers and the general public;
- evaluating research of cost effective programs.

We put forward the suggestion that a joint plan of action be drawn up with a view to realising the goals of wider dissemination of this type of program. A similar co-operation existed in the past between the University of Bristol, the Dutch Kruiswerk Gezinszorg

Breda and the Eastern Health Board in Dublin and nowadays between the Netherlands Institute of Care and Welfare, the MIM Co-operative and the Birmingham Health Authority with a view to an international exchange of experiences. This joint plan of action could also include a first step towards developing a research proposal for an international evaluation study. The participants at the conference discussed the possibility of setting up a newsletter with a view to information exchange. Finally, a biennial (inter)national "*Community Mothers Day*" was suggested, which could be coupled with an international conference where mothers, health care workers and others could meet to exchange their experiences and learn from each others different expertise. The suggested Community Mothers Day could be an ideal platform for everyone to see and acknowledge that the participating mothers are all and everything in these programs.

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The Netherlands Institute of Care and Welfare / NIZW

The Netherlands Institute of Care and Welfare / *NIZW* is an independent institute for renewal and improvement that renders services to organisations and professionals in the care and welfare sector offering assistance with regard to anticipating to new developments and safequarding the quality of the services. The *NIZW* works in close co-operation with these organizations to develop methods, organize work conferences, design quality improving instruments, and seek adequate forms of co-operation between the organizations. The results and experiences are subsequently published in books and newsletters and presented through conferences and videos.
In addition to renewal and improvement, the institute aims at strengthening the sector as a whole, a task entrusted primarily to the *Centrum voor Beroeps- en Opleidingsvraagstukken* (Centre for Professional and Vocational Training Affairs) and *the Informatiecentrum Zorg en Welzijn* (Information Centre of Care and Welfare). The International Centre offers its intermediary and supporting services for co-operation on international levels.

NIZW's activities focus on various fields of the sector, including nursery activities, youth welfare work. social work, services for the elderly, social-cultural work, crisis centres, nursing homes, home care and assistance to the physically or mentally handicapped. All in all, more than 400,000 professionals and many volunteers are active in this sector. The *NIZW* seeks to render services to this segment of the workforce by means of their products and, in addition to this, the *NIZW* increasingly offers its information to the actual consumers of services in the sector.

The MIM Co-operative

The MIM Co-operative is a partnership of regional community nursing agencies and the Netherlands Institute of Care and Welfare. The main goal of the Co-operative is the large-scale implementation of the Dutch program *Mothers inform mothers*. The MIM Co-operative offers its (potential) partners professional support, program development and evaluation. Activities such as publishing, organizing conferences and providing information also belong to its regular tasks. In the coming years more community nursing agencies will probably join in as partners of this national network.

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COMMUNITY HEALTH, COMMUNITY CARE, COMMUNITY SUPPORT

In this book we bring you the state of the art of different, early childhood care and development support programs. They come from Ireland, the United States of America, the United Kingdom and the Netherlands. These programs are supporting inexperienced parents whilst making use of experienced parents in their neighbourhood. The subject of these community based pragrams is child care and child rearing of young children aged 0 to 24 months.

We have focused on five topics:

- implementation of innovative support programs,
- specific target groups,
- the role of non-professionals in delivering health and welfare services,
- research on this kind of ECCD support programs,
- strategies of development and dissemination of early childhood care and development support programs.

Different authors have addressed these topics in depth and from different angles.

This book is of special interest to all people working with inexperienced parents of very young children, such as community nurses, health visitors, childcare workers, social workers, medical practitioners, pedagogists, and developmental psychologists.

Supported by a special grant of the Bernard van Leer Foundation, we are able to offer you both a theoretical view and practical reflections on community-based support programs for parents and children in need.

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